Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Meeting of the Foundation Trust Board of Directors
Wednesday 25th January 2017
Redesmere, Countess of Chester Health Park, Chester
1.30pm

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
16/17/103	Apologies for absence	Receive apologies	Verbal	Chair	1 min (1330)
16/17/104	Declarations of Interest	Identify and avoid conflicts of interest	Verbal	Chair	2 min (1331)
16/17/105	Minutes of the previous meeting held 30th November 2016	Confirm as an accurate record the minutes of the previous meetings	Written minutes	Chair	2 mins (1333)
16/17/106	Matters arising and action points	Provide an update in respect of ongoing and outstanding items to ensure progress	Written action schedule and verbal update	Chair	2 mins (1335)
16/17/107	Board Meeting 2016/17 business cycle	Confirm that agenda items provide assurance that the Board is undertaking its duties	Written	Chair	3 mins (1337)
16/17/108	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	10 mins (1340)
16/17/109	Chief Executive's announcements *(including overview of items discussed in closed meeting)*	Announce items of significance not elsewhere on the agenda	Verbal	Chief Executive	10 mins (1350)

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Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
MATTERS FOR APPROVAL/ DECISION					
Strategy					
16/17/110	Strategic Risk Register and Corporate Assurance Framework	To approve the risk register and assurance framework	Written Report	Medical Director	10 mins (1400)
16/17/111	Quality Improvement Report	To note quality improvement report	Written Report	Medical Director	10 mins (1410)
Capability and Culture					
16/17/112	Zero Harm strategy – update	To note update on Zero Harm	Presentation	Medical Director	15 mins (1420)
16/17/113	Person Centred Framework	To note framework implementation	Written Report	Director of Nursing, Therapies and Patient Partnership	10mins (1435)
16/17/114	CQC Learning, Candour and Accountability report (and Southern Health) : CWP response	To note CWP response	Written Report	Director of Nursing, Therapies and Patient Partnership	10 mins (1445)
Measurement					
16/17/115	Benchmarking: Adult Mental Health	To note performance	Presentation	Medical Director	15 mins (1455)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
Process and Structures					
16/17/116	Safer Staffing: • a. Six monthly ward staffing report • b. Daily Ward Staffing figures: November/ December 2016	To note the ward staffing reports	Written Reports	Director of Nursing, Therapies and Patient Partnership	15 mins (1510)
16/17/117	Learning from Experience Report (T2)	To note LFE executive summary	Written Report	Director of Nursing, Therapies and Patient Partnership	10 mins (1525)
16/17/118	Mental Health Act report	To review MHA compliance	Written Report	Medical Director	10 mins (1535)
16/17/119	Living Wage	To review Living Wage rates	Written Report	Director of People and OD	10 mins (1545)
16/17/120	Q3 2016/17 reports • a. Infection, Prevention and Control Report • b.(i) CWP Safeguarding and (ii) Strategy 2017/20	To note the Q3 reports	Written Reports	Director of IPC/ Director of Nursing, Therapies and Patient Partnership	5 mins (1555)
Governance					
16/17/121	Matters of Governance: • CQC statement of purpose	To note matters of governance	Written Report	Director of Finance	5 mins (1600)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
16/17/122	Audit Committee reporting: • Chair's report of meeting held 10 January 2017	Review Chair's Report and terms of reference and any matters for note/ escalation	Written Report	Chair of Audit Committee	3 mins (1605)
16/17/123	Quality Committee reporting : • Chair's report of meeting held 4 January 2017	Review Chair's Report and any matters for note/ escalation	Written Report	Chair of Quality Committee	3 mins (1608)
16/17/124	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair/ All	5 mins (1611)
16/17/125	Any other business	Consider any urgent items of other business	Verbal or written	Chair	2 mins (1616)
16/17/126	Review of meeting	Review the effectiveness of the meeting (achievement of objectives/desired outcomes and management of time)	Verbal	Chair/All	2 mins (1618)
16/17/127	Date, time and place of next meeting: **Wednesday 29th March 2017, 9.30am Boardroom, Redesmere.**	Confirm arrangements for next meeting	Verbal	Chair	1620

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Minutes of the Open Board of Directors Meeting
Wednesday 30th November 2016
Board Room, Trust HQ, Redesmere commencing at 1.30pm

PRESENT	Mike Maier, Chair Dr Faouzi Alam, Medical Director Fiona Clark, Non-Executive Director Dr Jim O'Connor, Non-Executive Director Lucy Crumplin, Non-Executive Director Rebecca Burke –Sharples, Non-Executive Director Andy Styring, Director of Operations Tim Welch, Director of Finance Dr Anushta Sivananthan, Medical Director David Harris, Director of People and Organisational Development.
IN ATTENDANCE	Gary Flockhart, Deputy Director of Nursing Louise Brereton, Head of Corporate Affairs Louise Kitchener, Head of Education (for item 16/17/87a) Jane Woods, Interim Deputy Director of People and Organisational Development (for item 16/17/87a) Liz Matthews, Associate Director: Patient and Carer Experience (for item 16/17/89) Cath Hill, Director, AQUA Tim Jenkins, Emergency Planning Manager (for item16/17/94b) Rob Robertson, Public Governor Gus Cairns, Service User/ Carer Governor David Seiber, Mental Health UK
APOLOGIES	Sarah McKenna, Non-Executive Director Sheena Cumiskey, Chief Executive Avril Devaney, Director of Nursing, Therapies and Patient Partnership

REF	MINUTES	ACTION
16/17/80	**Apologies for absence** The Chair welcomed Board members to the meeting. Apologies were noted from Sheena Cumiskey, Avril Devaney and Sarah McKenna. The Chair also welcomed Gary Flockhart attending on behalf of Avril Devaney and Cath Hill, observing the meeting as part of the well-led governance review. The meeting was quorate.	
16/17/81	**Declarations of Interest** There was none.	
16/17/82	**Minutes of the previous meeting held 28th September 2016** The minutes of the meeting held 28th September 2016 were reviewed. The minutes of the meeting held 28th September 2016 were **approved** as a correct record.	

These minutes are an accurate record of the meeting subject to amendments agreed at the subsequent meeting.

16/17/83	**Matters arising and action points** The action log was reviewed. There were no outstanding actions.	
16/17/84	**Board 2016/17 Business Cycle** The business cycle was reviewed. A query was raised as to when the Mental Health Act report would be provided having been due in September. Dr Anushta Sivananthan reported that the report required benchmarking data from the CQC and would be provided as soon as this was received.	
16/17/85	**Chair's Announcements** Mike Maier announced the following: **Millbrook staff** The Millbrook team recently received an extraordinary 'Going the Extra Mile' award for their handling of the recent fire incident. Further thanks were extended from the Board to Tim Jenkins, Emergency Planning Manger and Gary Flockhart, Deputy Director of Nursing. **CQC community mental health survey results** Positive results have been received from the survey. This is scheduled later on the agenda. **Ian Davidson** Congratulations to Dr Ian Davidson, Consultant Psychiatrist who has been appointed to the role of Autism Champion by The Royal College of Psychiatrists to support the national 'Think Autism' programme. **CAMHS overall achievement in CYP MH service.** Our CAMHS service was awarded with the 'Overall Achievement in Children and Young People's Mental Health Services' accolade at this year's Breakthrough Positive Practice in Mental Health Awards. **CWP life** Our membership magazine CWP Life was awarded Gold in the Best Publication category at the Chartered Institute of Public Relations (CIPR) North West Pride Awards 2016. CWP Life was particularly commended for its commitment to ensuring the patient voice is always at the heart of each publication.	
16/17/86	**Chief Executive Announcements** Tim Welch provided an overview of the following issues. **Items discussed in the closed meeting** Tim Welch provided an overview of the key items discussed in the closed meeting. This included a synopsis of the transformation of Learning	

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	Disability services, the review of the draft Operational Plan 2017/19 and key financial risks and agreeing the Board's approach to the 2017/19 contracting round; this being that contracts will only be agreed if growth monies are forthcoming and priorities in Five Year Forward View for Mental Health are upheld. **Sustainability and Transformation Plans (STP)** STPs have been submitted and published. CWP is leading the mental health work-stream for the Cheshire and Merseyside STP. Through this, the Trust has set out the case for investment and the potential return on investment for the wider health system. The STP is not yet the finished article and the important next step is engagement and consultation. Local Health and Wellbeing Boards have not endorsed the STP. Their message is that greater engagement of primary care is required. **Central and East Cheshire redesign.** The Trust has recently welcomed members of the East Cheshire Overview and Scrutiny Committee to Springview and Bowmere to support understanding of the redesign proposals. The visits have been well received and future visits are planned to community services. (Louise Kitchener and Jane Woods joined the meeting)	
16/17/87	**Strategic Risk Register Escalation updates** **a. Apprenticeship levy** The Chair welcomed Louise Kitchener and Jane Woods to the meeting. Louise Kitchener reported that the risk around the apprenticeship levy had been escalated to better understand any risk to the financial plan. There are monies to draw down to support the levy which are available for two years. Work is continuing to understand how the Trust can maximise the funding. The levy also provides opportunity to develop roles across all levels. It will also link into nursing associate roles which will also be apprenticeships. The financial risk has been factored into the 2017/19 financial plan. 82 positions will be available building on the 22 apprentices already in the Trust. A discussion followed. The Board requested that this programme offers opportunity for young people involved with the Trust such as young advisers and through the Ancora school. Lucy Crumplin stressed the need to have the apprenticeship framework in place with training providers to ensure that apprenticeships can be progressed in the timescale available. A discussion followed regarding the need to use the apprenticeships to support Trust transformation, particularly in learning disability services where there is an aging workforce. There is also a need to avoid being organisation centric in approach and to ensure that the plans are system centred moving forward. (Louise Kitchener and Jane Woods left the meeting)	

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	b. Cyber Risk This risk had been escalated following review of the recent MIAA audit on cyber preparedness by Audit Committee. A set of proposals were discussed to inform the risk treatment plan. While agreeing that this issue requires Board ownership, caution was noted to ensure that this was treated proportionally. It was recognised that the small investment in firewall protection would further reduce the residual risk. It was also noted that MIAA have undertaken further work in this area reported at a recent conference. **Action:** To contact Tim Crowley for information to ensure connection is made between this risk and the work on the national data guardian review. The Board resolved to **note** the report.	**TW**
16/17/88	**Commercialisation of CWP Intellectual Property (IP)** Tim Welch introduced the report regarding the commercialisation of CWP IP. The Trust has had a degree of success with developing innovative products, however this has been limited by the absence of an appropriate vehicle to take products to market. It is proposed that CWP will establish a company limited by shares – 'Newco.' CWP will be the 100% shareholder and all net profits generated from the sales of IP will be distributed back into the Trust. This will offer a mechanism for developing innovative products which may previously have been stifled. Governance arrangements are in place. The Board resolved to **approve** the establishment of 'Newco' with 100% shareholding to CWP. (Liz Matthews joined the meeting)	
16/17/89	**CQC Community Health Survey: key findings** The Chair welcomed Liz Matthews to the meeting. Liz Matthews informed the Board that the Trust is continues to perform well in the survey results. The survey sampled 1850 individuals in January 2016 with a 29% response rate. This is comparable to other trusts and gives a good barometer of the people using our services recently and in the past. CWP performs better than average for majority of questions with the ongoing challenge is to maintain the ratings. There are three areas for improvement: • Patient knowledge of their care coordinator/ lead professional and awareness of how to access them. • Improving care reviews • Ensuring patients understand who to contact for issues occurring 'out of hours'. Actions are in hand to take these improvements forward. A discussion followed. Dr Jim O'Connor queried how progress with the improvements would be reported. This will form part of the Patient and	

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	Carer Experience subcommittee reporting to the Quality Committee. The emphasis is on locality ownership of the actions, but with support from the Patient Experience team. It was noted there is a need to understand why these gaps are arising as part of this work. Rebecca Burke-Sharples commented on the need to triangulate the information as similar messages have arisen from complaints. Dr Anushta Sivananthan suggested that the improvement work should link into the community services improvement forum to support with increasing ownership for driving the improvements. **Action:** LM to make contact with forums to share improvement plans.	**AD/LM**
16/17/90	**Freedom to Speak Up (F2SU) – six monthly report** Gary Flockhart presented the report on behalf of Andrea Hughes and highlighted work undertaken within the last six months. Fiona Clark queried how informal issues are reported. It was noted that Freedom to Speak Up is aimed at staff who feel things have not been addressed in the right way. The Board resolved to **note** the report. **Action:** Ensure Board business cycle includes six monthly reports on Freedom to Speak Up.	**LB**
16/17/91	**Serious Case Review – Child B** Gary Flockhart updated the Board on a recent serious case review. No one organisation was found to be at fault. The review resulted in findings in six areas: • Professional understanding in relation to risk and vulnerability. • Coordinated multi-agency planning and the role of the Care Plan. • Listening to and being guided by the voice of the child. • Managing family dynamics; family consultation. Responding to serious incidents and crisis. • Appropriate use of assessment tools and statutory power. • Single and multi-agency communication and information sharing systems. The Trust is actively involved in implementing the action plan particularly around principles of risk assessment and responding to needs of the whole family. Several actions are already completed or are in progress. Dr Jim O'Connor commented on the importance of safeguarding training. Through the safeguarding strategy, efforts are being made to improve safeguarding training take up and this is being specifically targeted at specific staff groups. The Board resolved to **note** the report.	

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16/17/92	**Wirral Council Ofsted Inspection Report and action plan** Gary Flockhart presented the report providing an overview of the recent Wirral Council Ofsted inspection. Gary Flockhart advised that although no CWP services were inspected, the Trust is actively engaged as a partner to support the Council improvement plan. Avril Devaney is a member of the Improvement Board established in response to the inspection outcome. Any actions for CWP will be reported via the Safeguarding subcommittee. **Action:** Outcomes of this improvement work to be reported to the Quality Committee and potentially a future board meeting to understand broader impacts and any wider learning for the Trust. The Board resolved to **note** the report.	**AD**
16/17/93	**Daily Ward Staffing figures: October 2016** Gary Flockhart presented the report and advised that CWP fill rates are favourable to other trusts. Ward managers have flexibility to assess what they need by shift and therefore good relationships between the collocated ward teams as shown in response to a recent staffing issue at Lakefield ward. Gary Flockhart confirmed that Occupational Therapists will be included in the six monthly report assessment – this is next due in January 2017. **Action.** To consider additions to the report with headlines of key issues to note or via the operational plan dashboard with potential triangulation through the quality committee on a quarterly basis. The Board resolved to **note** the report.	**AD/GF**
16/17/94	**Q2 2016/17 reports** Gary Flockhart provided the following quarterly reports to note: **Infection, Prevention and Control report Q2 2016/17** Gary Flockhart highlighted the four year commitment to IPC, including the approach via zero harm. The Board resolved to **note** the report. **CWP Safeguarding Q1/Q2 2016/17** Gary Flockhart provided an overview of Q1 and Q2 safeguarding activity. The Board resolved to **note** the quarterly reports. (Tim Jenkins joined meeting)	
16/17/95	**2015/16 Annual Reports** **Research and Development 2015/16** Dr Faouzi Alam presented the annual report and provided an overview of	

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	research activities undertaken during 2015/16. In total, 1250 patients were recruited in 2015/16 and CWP was the highest recruiting trust in the Cheshire and Wirral LDS. The Research Strategy was agreed last year and the Trust continues to work towards the achievement of the objectives set. Dr Taj Nathan has been appointed as the new Director of Research. **Emergency Planning 2015/16** The Chair welcomed Tim Jenkins to the meeting. Tim highlighted the key issues in the report including the Trust attaining full compliance for emergency preparedness planning against NHSE standards and Ancora House resilience planning. The Board extended their thanks to Tim and his team, in particular for their support with recent fire incidents and with overall Trust resilience. The Board resolved to **note** the reports.	
16/17/96	**Matters of Governance:** Tim Welch introduced the reports as follows: **Register of Seals 2015/16** The Board resolved to **note** the report **Integrated Strategy Governance: 2016 annual review** The Board resolved to **note** the report **Q2 2016/17 Trust Licence Compliance** The Board resolved to **note** the report	
16/17/97	**Audit Committee reporting:** • **Chair's Report of meeting held 1st November 2016** The Audit Committee Chair summarised proceedings at the last meeting. The Healthcare Quality Improvement Programme had been well received. There were no exceptions to note. The Board resolved to receive the Chair's Report.	
16/17/98	**Quality Committee reporting:** • **Chair's Report of meeting held 2nd November 2016** The Quality Committee Chair provided an overview of the last meeting. There were no exceptions to note. The Board resolved to receive the Chair's Report.	
16/17/99	**Review of risk impact of items discussed** There were no further issues of risk to note. The Chair offered those in attendance an opportunity to comment on the meeting proceedings.	

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16/17/100	**Any other business** There were no further items of business.	
16/17/101	**Review of meeting** The Chair summarised three key messages arising from the meeting: • Trust progress on improving cyber security. • Improvements to action arising from the community mental health • Making better use of the ward staffing report by including key headlines.	
16/17/102	**Date, time and place of the next meeting** Wednesday 25th January, 1.30pm, Boardroom, Redesmere.	

Signed

Chair

Date:

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Cheshire and Wirral Partnership NHS
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Action points from Board of Directors Meetings
November 2016

Date of Meeting	Minute Number	Action	By when	By who	Progress Update	Status
27.7.16	16/17/49	**QUALITY COMMITTEE REPORTING** To schedule a Board presentation on the work of the CRAC team at future meeting.	Nov/ Dec 2016	LB	Scheduled for February 2017 seminar	Closed
30.11.16	16/17/87b	**STRATEGIC RISK REGISTER ESCALATION UPDATES** To contact Tim Crowley for information to ensure connection is made between this risk and the work on the national data guardian review	Dec 2016	TW	Oversight of cyber risk to transfer to Records and Clinical Systems Group to better link NRG work.	Closed
30.11.16	16/17/89	**CQC COMMUNITY HEALTH SURVEY** LM to make contact with improvement forums to share improvement plans.	Dec 2016	AD/LM		Open
30.11.16		**FREEDOM TO SPEAK UP (F2SU) – SIX MONTHLY REPORT** Ensure Board business cycle includes six monthly reports on Freedom to Speak Up.	ASAP	LB	Added to 2017/18 business cycle	Closed

30.11.16	16/17/92	**WIRRAL COUNCIL OFSTED INSPECTION REPORT AND ACTION PLAN** Outcomes of this improvement work to be reported to the Quality Committee and potentially a future board meeting to understand broader impacts and any wider learning for the Trust.	March 2017	AD	Scheduled for March 2017 Quality Committee.	Closed
30.11.16	16/17/93	**DAILY WARD STAFFING FIGURES: OCTOBER 2016** To consider additions to the report with headlines of key issues to note or via the operational plan dashboard with potential triangulation through the quality committee on a quarterly basis.	Jan 2017	AD/GF	Future reports to take account of changes.	Open

Cheshire and Wirral Partnership NHS Foundation Trust
Board of Directors meeting Business Cycle 2016/17

Cheshire and Wirral Partnership NHS Foundation Trust

No:	Agenda Item	Executive Lead	Responsible Committee/ Subcommittee	27/04/2016 Seminar	25/05/2016	29/06/2016 Seminar	27/07/2016	28/09/2016	26/10/2016 Seminar	30/11/2016	22/12/2016 Seminar	25/01/2017	22/02/2017 seminar	29/03/2017
Well Led Domain 1: Strategy														
1	**Operational Plan 2017-18approval of submission**	Director of Finance	Operational Board											✓
2	**Receive Annual Report, Accounts and Quality Account**	Director of Finance	Audit Committee (Quality Committee for QA)		✓									
3	**Integrated Governance Framework**	Medical Director Compliance Quality and Regulation	Quality Committee					✓						
4	**Quality Improvement Reports**	Medical Director Compliance Quality and Regulation	Quality Committee		✓			✓				✓		
5	**Strategic Risk Register and Corporate Assurance Framework**	Medical Director Compliance Quality and Regulation	Quality Committee		✓			✓				✓		✓
Well Led Domain 2: Capability and Culture														
6	**CQC Community Patient Survey Report 2015/16 and Action Plan**	Director of Nursing, Therapies and Patient Partnership	Operational Board					✓						
7	**Equality Act Compliance**	Director of Nursing, Therapies and Patient Partnership	Operational Board					✓						
8	**Zero Harm strategy reporting**	Medical Director Compliance Quality and Regulation	Quality Committee									✓		
9	**Staff survey 2015/16**	Director of HR and OD	People and OD subcommittee (Operational Board)											✓
10	**Freedom to speak up six monthly report**	Director of Nursing, Therapies and Patient Partnership	Operational Board					✓						
11	**Six monthly staffing review**	Director of Nursing, Therapies and Patient Partnership	Quality Committee/ Operational Board				✓					✓		
Monitor Well Led Domain 3: Process and Structures														
13	**Receive and Approve Quarterly Monitor returns** (no longer required post Q2/ SOF)	Director of Finance	N/A	✓			✓		✓			✓		
14	**Receive Learning from Experience Report executive summary**	Director of Nursing, Therapies and Patient Partnership	Quality Committee		✓			✓				✓		
15	**Assessment of Quality Governance** (no longer required post Q2)	Medical Director Compliance Quality and Regulation	Quality Committee		✓		✓		✓			✓		
16	**Declarations of Interest: Directors and Governors**	Chair	Audit Committee		✓									

17	**CEO /Chair Division of Responsibilities**	Chair	N/A											✓
18	**Care Quality Commission Registration Report**	Director of Finance	Operational Board										✓	
19	**Receive Quarterly Infection Prevention Control Reports**	Director of Infection Prevention and Control	Infection, Prevention and Control subcommittee (Quality Committee)		✓			✓		✓			✓	
20	**Director of Infection Prevention and Control Annual Report 2015/16 inc PLACE**	Director of Infection Prevention and Control	Infection, Prevention and Control subcommittee (Quality Committee)				✓							
21	**Safeguarding Children Annual Report 2015/16**	Director of Nursing, Therapies and Patient Partnership	Safeguarding subcommittee				✓							
22	**Quartely Safeguarding Report**	Director of Nursing, Therapies and Patient Partnership	Safeguarding subcommittee				✓	✓		✓			✓	
23	**Safeguarding Adults Annual Report 2015/16**	Director of Nursing, Therapies and Patient Partnership	Safeguarding subcommittee				✓							
24	**Accountable Officer Annual Report inc. Medicines Management 2015/16**	Medical Director Compliance Quality and Regulation	Medicines Management Group (Quality Committee)				✓							
25	**Health and Safety Annual Report and Fire 2015/16 and link certification**	Director of Nursing, Therapies and Patient Partnership	Health, Safety and Well-being subcommittee (Operational Board)				✓							
26	**Receive Appraisal Annual Report 2015/16 and annual declaration of medical revalidation**	Medical Director of Effectiveness and Medical Workforce	People and OD subcommittee (Operational Board)				✓							
27	**Emergency Planning Annual Report 2015/16**	Director of Nursing, Therapies and Patient Partnership	Emergency Planning subcommittee (Operational Board)					✓						
28	**Monthly Ward Staffing update**	Director of Nursing, Therapies and Patient Partnership	Quality Committee		✓		✓	✓		✓			✓	✓
29	**Provider Licence Compliance**	Director of Finance	Audit Committee		✓					✓				
30	**Security Annual Report 2015/16**	Director of Operations	Health, Safety and Well-being subcommittee (Operational Board)					✓						

31	**Mental Health Act compliance report (KP90)**	Medical Director Compliance Quality and Regulation	Compliance, Assurance and Learning subcommittee (Quality Committee)		✓					✓				
32	**Receive Register of Sealings Report**	Director of Finance	Audit Committee					✓						
33	**Receive Research Annual Report 2015/16**	Medical Director Effectiveness Medical Education	Operational Board					✓						
	Monitor Well Led Domain 4: Measurement														
34	**Information Governance 15/16 Toolkit**	Medical Director	Records and Clinical Systems Group (Quality Committee)												✓
35	**Board Performance Dashboard**	Director of Finance	Operational Board		✓		✓	✓		✓		✓			✓
	Governance														
36	**Receive minutes and Chair's Report of the Quality Committee**	Non Executive Director	N/A		✓		✓	✓		✓		✓			✓
37	**Receive minutes and Chair's Report of the Audit Committee**	Non Executive Director	N/A		✓		✓	✓		✓		✓			✓
38	**BOD Business Cycle 2016/17**	Chair	N/A		✓		✓	✓		✓		✓			✓
39	**Approve BOD Business Cycle 2017/18**	Chair	N/A												✓
40	**Review Risk impacts of items**	Chair/All	N/A		✓		✓	✓		✓		✓			✓
41	**Chair's announcements**	Chair	N/A		✓		✓	✓		✓		✓			✓
42	**Chief Executive announcements**	Chief Executive	N/A		✓		✓	✓		✓		✓			✓

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Corporate assurance framework and strategic risk register – update report
Agenda ref. no:	16/17/110
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and Approval
Date of meeting:	25/01/2017
Presented by:	Dr Anushta Sivananthan, Medical Director

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	Yes
All strategic risks	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	Yes
N/A	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*

To update the Board of Directors of the current status of the corporate assurance framework (incorporating the strategic risk register) to inform discussion of the current risks to the delivery of the organisational strategic objectives, and as per the requirements outlined within the Trust's integrated governance strategy. The report indicates progress against the mitigating actions identified against the Trust's strategic risks and the controls and assurances in place that act as mitigations against each strategic risk.
As at January 2017, the Trust has 4 red and 5 amber strategic risks.

Background – *contextual and background information pertinent to the situation/ purpose of the report*

The Board of Directors monitors and reviews the corporate assurance framework and receives assurances on risk via the Quality Committee. This is a key component of the Trust's integrated governance strategy which provides assurance regarding the quality and safety of the services that the Trust provides. The Quality Committee undertakes individual in-depth reviews of risks, with the Audit Committee undertaking periodic reviews of risk treatment processes for individual risks on an escalation/ enquiry basis.

Assessment – *analysis and considerations of options and risks*

New risks/ risks in-scope

Operational impact of redesign of Adult and Older People's Mental Health Services Central and Eastern Cheshire. This risk remains in-scope and is being is informed by discussion at the January Operational Board in relation to service resilience in the Central & East Cheshire locality.

An in-scope *risk that the CWP workforce not having sufficient capability (capacity, confidence, competence) and resilience to deliver place-based systems of care* is currently being developed by the Interim Deputy Director of People & Organisational Development to understand the degree and nature of the risk as it applies to CWP. This will look to amalgamate the following workforce risks wherever possible and will be concluded by the end of January 2017 with regular updates provided to the People and Organisational Development Sub Committee:

Risk 11 – *Failure to maintain…the right number of staff…to deliver effective…services against changing needs*.
Risk 16 – *Risk of insufficient junior doctor cover.*
Risk in-scope – *Risk of impact on patient care due to the staffing pressures in CMHTs Trustwide.*

Following discussion at the January Audit Committee, risks around non-achievement of CIP and commissioners' not sufficiently investing in priority services of the types provided by CWP have been identified. This has initially been included as a combined in-scope *risk of failure to achieve Trust control total due to under-achievement of cost improvement programme (CIP) and potential under investment of targeted resources by commissioners*.*

Archived risks

In line with the commitment at the last Quality Committee, the Associate Director of Safe Services has undertaken work to challenge a number of longstanding strategic risks for their currency and in conjunction with the risk leads and owners, a total of 7 risks have been archived, as follows:

Risk 1: *Apprenticeship Levy.* This risk has been accepted and has a robust implementation plan which is being monitored through the Education Governance Group.
Risk 2: *Compliance with the intercollegiate document Safeguarding children, 2014*
Risk 4: *Implementation of lessons from the Bradbury and Savile (safeguarding) inquiries.* These are being monitored routinely through the Safeguarding Sub Committee.
Risk 5: *Compliance with CARSO risk assessment as per policy.* Greater specificity about the degree and nature of this risk will be determined by the learning themes quality improvement project.
Risk 6: *Effective investigation of serious incidents.* In December, the CQC published a national report which will be considered by the Board at today's meeting, alongside the current continuous improvement plan in place post-Mazar's report, to identify specific residual strategic risks for CWP.
Risk 8: *Fragmentation of commissioning leading to fragmented patient pathways.* The potential impact of under-investment in services is being scoped (as above*). Further, specific strategic risks will be scoped as commissioning landscapes evolve, especially in response to implementation of the STP.
Risk 15: *Risk of insufficient levels of cash being readily available to the Trust to meet day-to-day operational requirements, resulting in potential adverse financial performance and potential.* The Trust is now in a more favourable cash position than originally forecast due to contingencies linked to the construction of Ancora House, the re-prioritisation of estate rationalisation schemes, and differences in working capital.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*

The Board of Directors is asked to **review**, **discuss** and **approve** the amendments made to the corporate assurance framework following review of the strategic risk register at the January 2017 Quality Committee.

Who/ which group has approved this report for receipt at the above meeting?	Board of Directors – business cycle requirement
Contributing authors:	Louise Brereton, Head of Corporate Affairs Suzanne Christopher, Corporate Affairs Manager David Wood, Associate Director of Safe Services

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Quality Committee	28/12/2016
2	Audit Committee	05/01/2017
3	Board of Directors	18/01/2017

Appendices provided for reference and to give supporting/ contextual information:

Appendix no.	Appendix title
Appendix 1	Corporate assurance framework – January 2017

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Quality Improvement Report – Edition 2 2016/17
Agenda ref. no:	16/17/111
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and Approval
Date of meeting:	25/01/2017
Presented by:	Dr Anushta Sivananthan, Medical Director – Executive Lead for Quality

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	No
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	No
Be recognised as an open, progressive organisation that is about care, well-being and partnership	
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	No
Capability and culture	Yes
Process and structures	No
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
N/A	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
N/A	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*

The purpose of this report is to update the Board of Directors on Edition 2 of the Quality Improvement report for 2016/17. This report is produced three times a year with the aim of updating people who access and deliver the Trust's services, and other stakeholders, on progress in improving quality across CWP's services. The report describes projects that are improving the quality of patient safety, clinical effectiveness and patient experience. Going forward, the report will also illustrate other elements of quality as detailed in the Zero Harm strategy; these are accessible, sustainable, acceptable, affordable and equitable services.

Background – *contextual and background information pertinent to the situation/ purpose of the report*

The Quality Improvement report builds on the success of the previous Quality report which has been published quarterly for several years. The aim of the Quality Improvement report is to provide a more detailed focus on individual projects, describing the aims, methodology, results and next steps of quality improvement efforts. The second edition of the Quality Improvement report was approved by the Quality Committee on 04/01/2017.

Assessment – *analysis and considerations of options and risks*

Alongside the Best Practice portal and the annual Big Book of Best Practice, the Quality Improvement report is a vehicle for staff to share examples of quality improvement projects, share learning and celebrate successes. The report describes projects in an accessible way with the aim of encouraging more staff to get involved in quality improvement in their areas. The Healthcare Quality Improvement team will be working with clinical teams to ensure that examples of best practice are publicised and that a culture of sharing best practice and learning becomes embedded. The report will be shared via CWP Essential and via email to ward and team managers, and management teams; copies are also provided to the Trust's Governors and external stakeholders including commissioners.

Headlines this edition include:

- CWP's Tissue Viability team has sustained continuous reductions in the incidence of avoidable pressure ulcers.
- The annual Best Practice Event has showcased many examples of quality and quality improvement.
- CWP has been recognised for its care and quality improvement at the North West Leadership Academy Awards.
- CWP has launched its Suicide Prevention Strategy.
- A specialist perinatal community mental health service has secured funding to support new and expectant mums by providing access to high quality care.
- High quality standards of care and facilities for CWP patients have been demonstrated through patient led assessments of the care environment
- CWP wards have signed up to a national dementia campaign, supporting person-centred care.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*

The Board of Directors is asked to **endorse** Quality Committee's approval of this report.

Who/ which group has approved this report for receipt at the above meeting?		David Wood, Associate Director of Safe Services
Contributing authors:		Helen Fishwick, David Wood
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	H Fishwick to D Wood	14/12/2016
2	D Wood to L Brereton for Board of Directors	16/01/2017

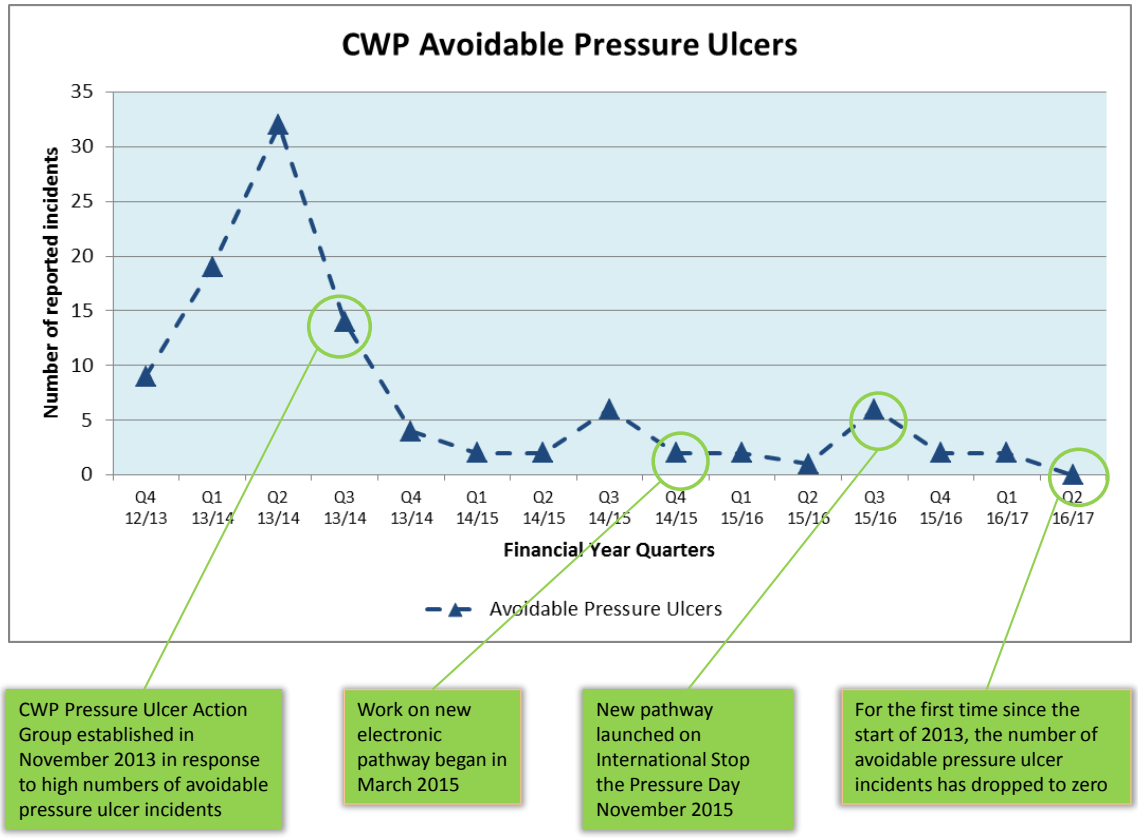
Appendices provided for reference and to give supporting/ contextual information:	
Appendix no.	Appendix title
1	Quality Improvement Report, Edition 2 2016/17

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Quality Improvement Report

Edition 2
August – November 2016

Vision:
Leading in partnership
to improve health and well-being by providing high quality care



CWP Pressure Ulcer Action Group established in November 2013 in response to high numbers of avoidable pressure ulcer incidents

Work on new electronic pathway began in March 2015

New pathway launched on International Stop the Pressure Day November 2015

For the first time since the start of 2013, the number of avoidable pressure ulcer incidents has dropped to zero

Successfully reducing the number of avoidable pressure ulcers – see page 4

Care • Well-being • Partnership

Welcome to CWP's second *Quality Improvement Report* of 2016/17

These reports are produced three times a year to update people who access and deliver the Trust's services, carers, the public, commissioners, internal groups, and external scrutiny groups on progress in improving quality across CWP's services, which CWP is required to formally report on in its annual *Quality Account*.

CWP's *Quality Account* and *Quality Improvement Report*s are available via:

http://www.cwp.nhs.uk/our-publications/reports/categories/431

Reporting on the quality of the Trust's services in this way enhances involvement of people by strengthening the Trust's approach to listening and involving the public, partner agencies and, most importantly, acting on the feedback the Trust receives.

At CWP, we are starting to look at ***quality*** in more detail to better demonstrate where we are making real improvements, with the aspiration to achieve **equity** of care through ***quality improvement***. The next edition will focus in more detail on other areas of quality such as the **accessibility**, **affordability** and **sustainability** of care.

QUALITY					
Patient safety	Clinical effectiveness			Patient experience	
Safe	Effective	Affordable	Sustainable	Acceptable	Accessible
Achieving Equity and Person-centred Care through CO-PRODUCTION, CO-DELIVERY, QUALITY IMPROVEMENT & WELL-LED SERVICES					
Delivering care which minimises risks	Delivering care that follows an evidence base and results in improved health outcomes, based on people's needs	Delivering care in a way which maximises use of resources and minimises waste	Delivering care that can be supported within the limits of financial, social and environmental resources	Delivering care which takes into account the preferences and aspirations of people	Delivering care that is timely, geographically reasonable, and provided in a place where skills and resources are appropriate to meet people's needs
"Being treated in a safe environment"	*"Receiving care which will help me recover"*			*"Having a positive experience"*	
"Being protected from harm and injury"	*"Having an improved quality of life after treatment"*			*"Being treated with compassion, dignity and respect"*	

This report is just one of many reviewed by the Trust's Board of Directors that, together, give a detailed view of CWP's overall performance.

This *Quality Improvement Report* provides a highlight of what CWP is doing to continuously improve the quality of care and treatment that its services provide. It also provides examples of **quality improvement** projects.

EXECUTIVE SUMMARY
QUALITY IMPROVEMENT HEADLINES THIS EDITION

CWP Tissue Viability team sustain continuous reductions in the incidence of avoidable pressure ulcers
➲ see pages 4

Best Practice Event showcases quality improvement
➲ see page 8

Recognition for CWP for its care and quality improvement at North West Leadership Academy Awards
➲ see page 9

CWP's Suicide Prevention Strategy
➲ see pages 10

Specialist perinatal community mental health service secures funding to support new and expectant mums by providing access to high quality care
➲ see page 13

High quality standards of care and facilities for CWP patients demonstrated through patient-led assessments of the care environment
➲ see page 14

CWP wards sign up to national dementia campaign, supporting person-centred care
➲ see page 15

An explanation of terms used throughout this report is available on the Trust's internet:
http://www.cwp.nhs.uk/reports/1628-quality-reporting-glossary

Tissue Viability team successfully sustain continuous reduction in avoidable pressure ulcers in the community

Our front page shows how we have used **Quality Improvement** to significantly reduce the numbers of avoidable pressure ulcers occurring in the people we provide care and treatment to in the community.

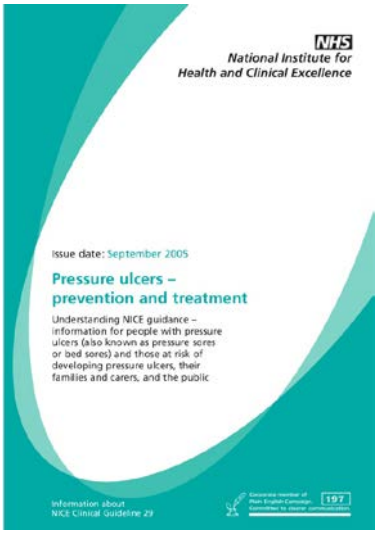
Figures for quarter 2 of 2016/17 show that there has been a further **sustained improvement** in the number of avoidable pressure ulcers reported by the Trust. In the twelve months to June 2015, 13 out of 95 stage 3 or 4 pressure ulcers were deemed avoidable (which equates to 14%). Stage 3 and 4 pressure ulcers are the most severe stages where there is significant skin and tissue damage and risk of infection. In the twelve months to June 2016 (i.e. one year on) the corresponding figures were 10 out of 111 (or 9%). In other words, the number of pressure ulcers being identified and treated went up, and the proportion of avoidable pressure ulcers went down. This shows sustained improvement in the care we provide and demonstrates how our **staff are learning from incidents by reflecting on their practice.** What's more remarkable is that, prior to November 2013 when the CWP *Pressure Ulcer Action Group* was set up, the number of avoidable pressure ulcers was running at an average of 6 a month.

In this November's incident analysis, it demonstrates the longest run of months without a single avoidable pressure ulcer incident reported. None were reported for six months – in June, July, August, September, October and November.

To-date, the project has successfully achieved:

- A reduction in the proportion of serious pressure ulcers, which were deemed avoidable, of five percentage points, from 14% in the 12 months to June 2015 to 9% in the 12 months to June 2016.
- Increasingly long runs without an avoidable pressure ulcer being identified.

This is one example of many in the Trust that shows how our staff are embracing our Zero Harm campaign, which is about **supporting people to deliver the best care possible**, as safely as possible and in doing so reducing unwarranted avoidable harm. Through **collaboration, learning, sharing knowledge and listening and responding**, we have achieved real improvements in the way we deliver care to people and we attribute this success to:



Setting up the Pressure Ulcer Action Group in November 2013

Using quality improvement methodologies such as driver diagrams and PDSA cycles to drive the project.

Ongoing statistical support from Quality Surveillance Analysts to monitor progress.

Developing the interactive pressure ulcer pathway

In conjunction with a software design company, and CWP IT services, the team developed a pathway for use in the community and made it accessible using iPads (see page 5).

The pathway has all the relevant information about the management and treatment of pressure ulcers.

Staff now have instant up-to-date information and guidance on the management and treatment of all stages of pressure ulcers and discharge care.

A comprehensive training programme on pressure ulcer prevention and treatment

Monthly Zero Harm meetings to learn lessons and share good practice

Early in 2017, the team will share their project with representatives from *NHS Improvement*. The Head of Mental Health Policy and Strategic Advisor for Nursing from *NHS Improvement* will be visiting the Trust to see for themselves the quality improvement that has been achieved and sustained. The Tissue Viability team has also had their project accepted for a poster presentation at the *International Forum on Quality and Safety* conference to be held in London in April 2017 (see next page).

Interactive Pressure Ulcer Pathway Project recognised at international conference

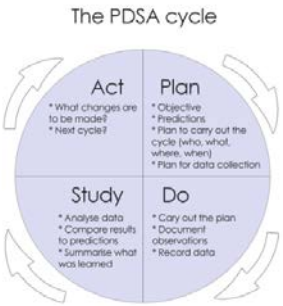
The Tissue Viability Team has had a poster accepted for presentation at an international conference. The *International Forum on Quality and Safety in Healthcare* is one of the world's largest gatherings of healthcare professionals committed to improving patient care and their safety. In April 2017, the International Forum will be held in London and will be attended by over 3,000 healthcare leaders and practitioners from around 70 countries.

Background:

The Tissue Viability Team wanted to provide Community Care Teams to have 'at a glance' pressure ulcer information and guidance using iPads. The work was undertaken by the Tissue Viability Team who, amongst other duties, provides support for community staff in the prevention and treatment of pressure ulcers. Pressure ulcers are a significant health risk which cause pain and suffering to the individual and significant expenditure to the NHS in terms of staff time and expenditure. The number of avoidable pressure ulcers is a key quality measure and our aim was to reduce variance so the number reduces.

What did we want to achieve?

Routine monitoring of pressure ulcers against national figures indicated that there was scope for reduction. Using PDSA cycles, we worked with key stakeholders to identify causes of variance and to explore potential solutions. As part of the Trust's Zero Harm strategy we had monthly meetings where we looked at practice and drew lessons, which fed into driver diagrams and PDSA cycles. The findings from this stage were that paper-based policy approaches were impractical, potentially out-of-date and not easy to use in a domestic setting. The old system did not facilitate action plans and made it difficult to capture, thus increasing strain on staff.



What we did:

In conjunction with the developers of CWP's intranet, an interactive pressure ulcer pathway was designed for use in the community and made accessible using iPads. The pathway has all relevant information about the management and treatment of pressure ulcers. Community Care Team staff were involved in the workshops and the team also worked alongside the CWP IT department to deliver an effective product.

It was decided early on that an electronic solution was the way forward. The electronic pathway was designed using further PDSA cycles. The pathway was discussed in focus groups and iteratively developed with internal and external partners. A dummy site was created to test the practical application of the theory. Further iterations led to a final agreed model. In order to ensure the launch was successful, the pathway was tested by focus and preparatory groups.

Funding initially came from a relative of a patient who had been positively treated for pressure ulcers in the community. The IT department built an electronic tissue viability pathway using relevant documents, photographs and information supplied by the Tissue Viability team. The process took around 8 months. The pathway was launched on the global *STOP Pressure Ulcer Day* in November 2015. All staff were involved in the development and were able to feedback via the Zero Harm meetings. Data was routinely gathered on avoidable pressure ulcers and monitored in monthly meetings and the same method was used pre and post intervention.

Results:

The aim of the project was achieved and there was reduced variation, with the benefits of patients receiving evidence based care and staff being supported in their clinical decision making. Using an electronic pathway facilitated new starters' induction and continuing professional development. It also enabled the Tissue Viability team and the IT department to look for solutions for the IT issues faced by rural teams. Staff now have instant, up-to-date information and guidance on the management and treatment of all stages of pressure ulcers and discharge care.

Successful year for CWP Research Team

What did we want to achieve?

Research, and its evidence translated into practice, is vital in transforming services and **improving patient outcomes** across the NHS. CWP embraces its mandate to prioritise and grow research as part of its core business and has identified the following three priorities to be addressed during the period of the approved CWP Research Strategy for 2015 – 2018:

Priority 1 Raise the profile of CWP research internally and externally
Priority 2 Strengthen links with external partners
Priority 3 Secure external funding from academia and/ or industry

What did we do?

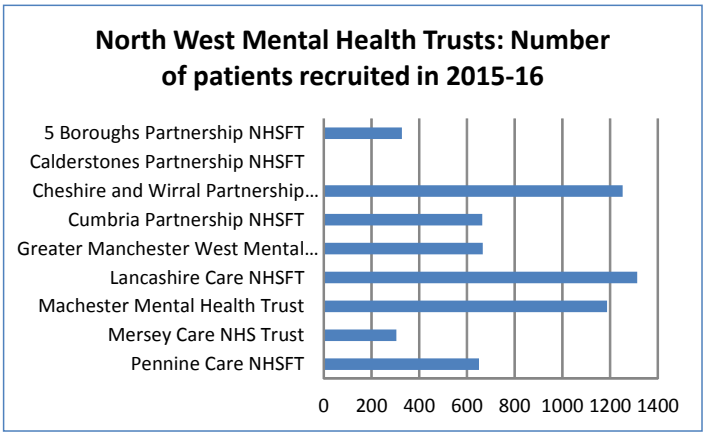
The Trust's annual research report for 2015/16 has recently been published and this demonstrates CWP's commitment to supporting ground breaking research. In the last year, the Trust has:

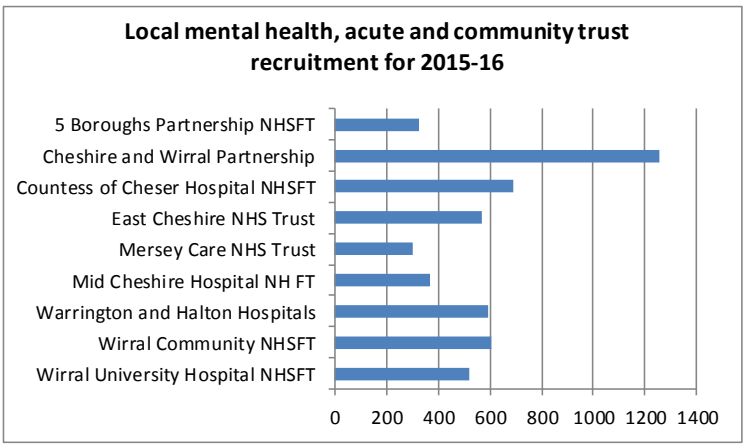
- Participated in a high number of studies including:
  - a prestigious "first in man" trial testing a vaccine to determine if it slows the progression of Alzheimer's disease
  - a genetic study examining the risk of developing Dementia in those with Down's syndrome
  - an agitation in dementia study
- Undertaken work to increase the number of staff undertaking 'Principal Investigator' training, increase the number of staff being actively involved in research and encourage publications in high impact journals
- Developed a "consent to contact" process by which people are able to express their interest in taking part in research within the Trust and agree to research staff checking their eligibility against study protocol inclusion/ exclusion criteria
- Hosted a very successful research conference which provided information in respect of research that has taken place in CWP related to:
  - Adverse drug reactions to clozapine.
  - Memory Assessment Service.
  - The benefits of Minocycline on negative symptoms in psychosis.

Results

The 2015 – 2018 Strategy outlined a target of 500 participants for the financial year but CWP **successfully recruited over double this number** achieving 1,253 participants by year-end. This is an increase of 684 over the previous year's figures. The graph to the right demonstrates that **CWP is one of the highest recruiting mental health trusts in the North West Coast Area**. (Figures taken from the NHS Portal.)

During 2015/16, there were 17 new studies and 34 existing studies to recruit to.





In the context of the Cheshire and Wirral Local Delivery System (LDS), CWP is, by far, the **highest recruiting organisation** for 2015/16, as evidenced by the graph to the left.

Next Steps

CWP will aim to maintain its high standards of recruitment to research studies and will continue to encourage staff to take part in and use research in their practice in the coming years to **facilitate improved outcomes.**

CWP Prone Position Restraint Reduction work to be published and presented

In February 2015, CWP identified an "Accelerating Restraint Reduction" Quality Improvement project, sponsored by the Medical Director. This was in response to national benchmarking data which suggested that we were reporting more incidents than the national average. Through implementing the project, as well as significantly reducing the number of prone position restraint incidents, there is clear evidence that staff are progressively using more de-escalation techniques. Quality Surveillance Analysts from the Safe Services Department continue to monitor ongoing progress and improvements are being sustained to-date.

An academic paper describing CWP's approach to reducing prone position restraint has been accepted for publication in the *International Journal of Health Governance*. A multidisciplinary team, led by Dr Elizabeth Shaw (previously a trainee grade doctor at CWP), and sponsored by Dr Anushta Sivananthan, Medical Director, audited CWP's approach to using prone position restraint, which in turn has significantly and sustainably reduced the number of restraint incidents. The paper entitled *"Use of prone position restraint within a mental health trust – a clinical audit of psychiatric practice and methods for improvement"* was co-authored by Elizabeth Shaw, Anushta Sivananthan, David Wood, James Partington, Alison Reavy, and Helen Fishwick. The published version will be available in April 2017.

A poster describing this project has also been accepted for presentation at the *International Forum on Quality and Safety in Healthcare* and is summarised below:

Accelerating restraint reduction – A Zero Harm approach

International Forum on QUALITY & SAFETY in HEALTHCARE

What we did:

The extent of CWP's outlying performance in relation to prone position restraint was assessed through analysis of incident reporting at ward levels via the Learning from Experience report to Board. Frontline clinical staff were involved in the project via task and finish groups, and there was Trustwide communication about the project. A meta-analysis, including the clinical audit mentioned above, was undertaken to fully understand the issues associated with the Trust's practice and to identify improvement actions. In addition, Matrons undertook a 72 hour reflective review of each restraint incident, including staff de-briefs, and patients were asked about their experience of being restrained.

Results:

As well as an initial 50% reduction in the use of prone position restraint, which monitoring has demonstrated has been sustained, the project has also resulted in a behavioural change, with incident reporting demonstrating increases in de-escalation techniques to manage challenging behaviour. This indicates a number of positive benefits for patients, since the evidence highlights the psychological and physical harm that prone position restraint can cause.

We have attributed the sustained improvements and spread to a number of factors, not least reflective practice reviews driving up data quality and enabling learning to be shared and implemented.

Lessons learned:

The success of the project has been linked to the following factors:

- Medical Director leadership
- A collaborative approach between clinicians and corporate support services.
- An effective initial meeting which involved all key stakeholders and gave a focused and practical project plan.
- Clinical staff and patient engagement.
- Robust and complete data, trusted by everyone, showing results of the intervention, pockets where work was still needed, and good practice examples.
- Using PDSA cycles to refine and carry out the change.

Best Practice event showcases quality improvement

Over 100 people who access/ have accessed CWP services, staff, partners and members of the public attended the annual Best Practice event at the Floral Pavilion Theatre in New Brighton in September.

The event included an exhibition of the most innovative and inspiring work carried out over the past year to ensure the best possible outcomes for people who access CWP services, their carers and families.

Over 35 different services from across the Trust showcased their achievements at the event.

Angie and Tony Russell, co-directors of the *Positive Practice in Mental Health Collaborative*, attended the event. The collaborative is a multi-agency organisation with a membership of over 80 professional bodies aiming to raise the profile of mental health. Speaking about the Best Practice event, Tony Russell said:

> What an inspiring event! We believe it's important to identify and share best practice in mental health. We therefore commend CWP for their excellent work and are proud to have them as key members of the Positive Practice in Mental Health Collaborative."

The annual Best Practice event is inspired by the Trust's Zero Harm campaign, which involves supporting everyone to deliver the best care possible, as safely as possible to reduce unwarranted avoidable harm and variation.

Dr Anushta Sivananthan, Medical Director and Executive Lead for Zero Harm, said:

> "I'm absolutely thrilled that we have an event that allows our nurses, doctors and therapists to share our achievements with the wider community. Knowing what good looks like is vital to improving all areas of the NHS, and it's so important that we are able to share learning gained form the achievements of others. That's what our Best Practice event is all about."

Just some of the teams showcasing their projects are pictured right. For more *best practice* stories, please see the Big Book of Best Practice or the Best Practice webpage.

Recognition for CWP at NHS North West Leadership Academy Awards 2016

Linda Johnstone (pictured right), Lead Nurse and Clinical Director, Substance Misuse Service, was the winner of the **Inspirational Leader** category at the *North West Leadership Academy* Recognition Awards 2016. Linda has 20 years' experience working in the field of substance misuse. She was one of the first nurse prescribers in Britain. She is committed to **providing quality care** to drug and alcohol users and works to **reduce the stigma** attached to people living with dependency. She believes in therapeutic partnerships with service users. Speaking about her nomination, Linda said she couldn't believe she had been nominated for an award and was very humbled by it.

The Safe Services Department was also shortlisted as a finalist in the category of ***"Team Outstanding Achievement – Non-Clinical"*** in the *NHS North West Leadership Academy's Recognition Awards 2016.*

The Safe Services Department leads the delivery of a "safety management system", underpinned by the Trust's "Zero Harm" strategy. Developed by the team's Associate Director, David Wood, it is an evidence-based framework to help clinical teams and the Trust to improve in their safety objectives. The project is delivered through an implementation plan, which has evidenced the achievement of many measureable benefits for people accessing and delivering the Trust's services, for example:

- Production of regular team-level "data packs" to promote **positive, safe** and **efficient** variance, aggregated to service-level to bring about improvement through benchmarking. One example of a clinical impact is described earlier in the report (a reduction in stage 3 and 4 pressure ulcers as monitored through the physical health community team data packs).

- Implementing a "patient safety improvement review" process to provide **a view of safety that is rounded, accurate and in real time**. It replaces traditional ways of testing reliability by instead measuring and monitoring care processes through a "healthcare quality improvement" approach.

- Implementing Human Factors education to help staff identify behavioural aspects that **promote a continuous improvement** approach – over 150 staff are "culture carriers" that jointly have made 200 pledges to promote safe care.

- Leading a **quality improvement** project to accelerate restraint reduction (described earlier in the report) using Human Factors principles – resulting in a sustained reduction of 50% in the use of prone position restraint across the Trust's inpatient services.

- Leading the Trust's *CQC* inspection, using tactics such as "share learning" bulletins to help staff to focus on care delivery rather than be distracted by compliance processes – resulting in an "Outstanding" rating for the Caring domain.

- Supporting staff to deliver good care by **sharing best practice and evidencing what good looks like** – through an electronic "best practice portal" and the aforementioned annual "Big Book of Best Practice" showcase event/ publication.

David Wood, Associate Director of Safe Services, pictured left with colleagues from the Safe Services Department at the ceremony, said:

"We were delighted and honoured to be nominated for the award. As a non-clinical team, it is an absolute privilege to support and enable our clinical colleagues to be the best they can be, and we are so proud of all of our collective and significant achievements in providing safer care."

QUALITY SUCCESS STORIES

CWP has set three **Trustwide quality priorities** for 2016/17, which reflect the Trust's vision of "**leading in partnership to improve health and well-being by providing high quality care**". They are linked to the Trust's strategic objectives, and reflect an emphasis on **patient safety**, **clinical effectiveness** and **patient experience**.

The Trust has made a commitment in its *Quality Account* to monitor and report on these in its *Quality Improvement Reports*. This year, the common focus across all the priorities is **reducing unnecessary avoidable harm** to help reduce avoidable variations in the quality of care and to improve outcomes.

This year, as well as setting a number of areas for overall continuous quality improvement, a number of goal driven measures aligned to the dimensions of the Trust's safety management system, and to the Trust's forward operational plan for 2016/17, have been set.

Patient Safety News

CWP Patient Safety priority for 2016/17 – Achieve a continuous reduction in unnecessary avoidable harm and make measurable progress to embed a culture of patient safety in CWP, including through improved reporting of incidents

Suicide Prevention Strategy

CWP marked **World Suicide Prevention Day** (10 September) with a suicide prevention workshop, drawing over 80 attendees, with speaker Angela Samata, former head of *Survivors of Bereavement by Suicide* (*SOBS*) and presenter of a BBC documentary *Life after Suicide*.

Speaking at the event, Angela said:

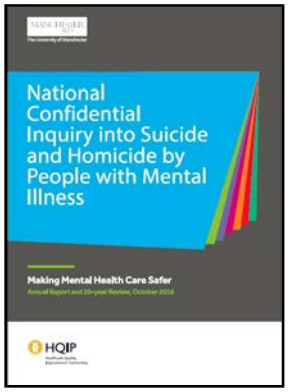
> "World Suicide Prevention Day can be the catalyst to an incredibly important conversation. Talking and sharing our stories is not the whole answer, but it's such a first positive step. Be honest and open – it's okay not to be okay."

Dr Anushta Sivananthan, Consultant Psychiatrist and Medical Director (pictured above, far left), said "**In the UK, there is a suicide attempt every 20 minutes and 70% of people who die by taking their own life are not in touch with mental health professionals – take that first positive step towards help, even if that means simply talking to a loved one.**"

As part of its Zero Harm strategy, CWP is committed to reducing the risk of suicide and has developed a four-year Suicide Prevention Strategy with partners across Cheshire and Merseyside. Audrey Jones, Head of Governance, has led this project, which is aligned to both national and regional strategies.

Suicide Strategy for CWP 2016 – 2020

The University of Manchester has led a *Confidential Inquiry into Suicide and Homicide by People with Mental Illness*. The annual report and a 20-year review 2016 presents findings from 2004 to 2014, and reviews 20 years of data collection. It provides the latest figures on suicide, homicide and sudden unexplained deaths and highlights the **priorities for safer services**.



Key messages include:

- Nationally, there are now around three times as many suicides by patients accessing care through Home Treatment teams as in inpatients.
- Many people who died by suicide had a history of drug or alcohol misuse, but few were in contact with specialist substance misuse services.
- More patients who died by suicide were reported as having economic problems, including homelessness, unemployment and debt.
- There has been a rise in the number of suicides by recent UK residents: those who had been in the UK for less than 5 years, including those seeking permission to stay.
- Most patients who committed homicide had a history of alcohol and drug misuse.

CWP's priorities for Suicide Prevention

CWP's four-year strategy is aligned to both the *National Suicide Prevention Strategy – NSPS* (Department of Health, 2012) and the Cheshire and Merseyside Suicide Strategy 2015 – 2020.

Year 1 priorities for CWP:

- Agree the education strategy.
- Set the direction of travel for transformation of services.
- Work with our partners to help Cheshire and Merseyside to become a "suicide safer community".
- Develop a suicide prevention e-learning module.

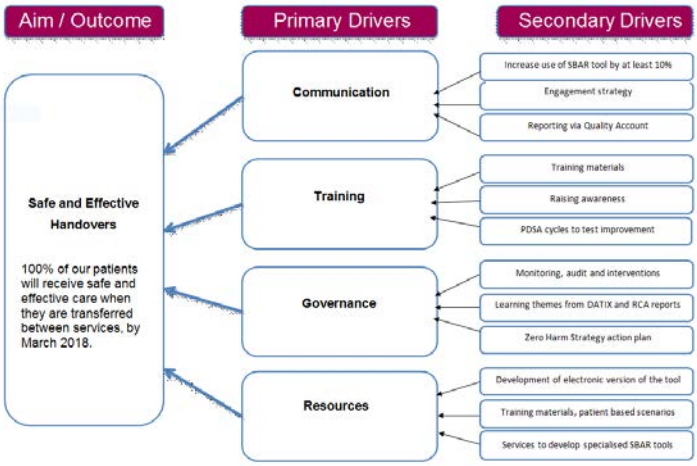
Cheshire and Merseyside NO MORE zero suicide strategy 2015 – 2020 main areas for action include:
A. Cheshire and Merseyside becomes a "suicide safer community".
B. The healthcare system transforms care to eliminate suicide for patients.
C. Support is accessible for those who are exposed to suicide.
D. A strong, integrated Suicide Reduction Network provides oversight and governance.

Safe and Effective Handovers and Transfers of Care

A multidisciplinary group are working on a project to improve transfers and handovers of care using 'SBAR' principles. SBAR stands for Situation, Background Assessment and Recommendation, and is a widely used communication tool which can be used to facilitate patient transfers and is evidenced based to decrease the incidence of harm. Members of the group have recently completed the *Applied Human Factors* training course facilitated by the *Advancing Quality Alliance*, and are applying their learning to different types of transfers and handovers of care throughout the Trust.

Pictured left are members of the group: Julie Acton, Kate Chapman, Nicky Robinson and Helen Fishwick, at Liverpool Medical Institution as part of their training course.

A safety challenge facing CWP teams are issues around communication associated with handovers and transfers of care. This is a recurring theme in learning from incidents in teams throughout the Trust. The group will be using their training to apply Human Factors thinking and approaches to this issue. Improving the safety of patient transfers and handovers of care by increasing the use of the SBAR tool is a goal driven measure for patient safety which is part of CWP's Quality Account for 2016/17.



Using Human Factors approaches has helped the group to understand and influence behaviours that will support safety improvements. These include systems and processes, policies, culture, resources, patterns in errors, and education and training.

For staff interested in improving transfers or handovers of care in their team or ward, and becoming involved with the group, please contact Helen Fishwick on 01244 393325.

Clinical Effectiveness *News*

CWP Clinical Effectiveness priority for 2016/17 – Achieve a continuous improvement in health outcomes for people using the Trust's services by engaging staff to improve and innovate

Education CWP receives 'Highly Commended' in the Care Coordination Association *Good Practice Awards*

The *effective care planning e-learning programme* produced by Education CWP has received a Highly Commended award in the CCA good practice awards, in the category "Improving Service User Care through Effective Learning and Development Strategies".

Ruth Gaballa, Education Manager, explains: "Our aspiration was to develop the effective care planning e-learning programme and make it useable for all CWP staff in all clinical areas."

Recommendations to improve patient safety in the NHS in England were made in the document 'A promise to learn – a commitment to act' and CWP responded to this with the Trustwide Zero Harm strategy. Don Berwick – founder, and former president of the *Institute for Healthcare Improvement*, shared his vision for investing in the growth and development of all staff and promoted the idea of 'All teach – All Learn' as a way to continually develop our learning.

Matthew Crouch, Education CWP's e-learning developer, incorporated good practice examples sent in from clinicians within CWP. Clinical areas were invited to share best practice and examples of "what good looks like" with others in order to reinvigorate care planning throughout CWP and ensure safe and effective outcomes for people who have care plans.

The e-learning package has been co-produced by the care planning task and finish group, led by Liz Matthews – Associate Director of Patient and Carer Experience, and CWP's Clinical Expert Champion for Zero Harm – Dr Ian Davidson.

Speaking about the learning package, Ruth said:

"It is a dynamic learning package and we want staff and people in CWP to be involved with sharing best practice with us. The e-learning will also be available on the Education CWP SharePoint as a resource for staff to access anytime and not just as a once a year mandatory training. We want to move away from e-learning as a 'have to do it' and move towards learning as a 'want to do it' way of learning and to do this we need your support".

Autism screening work to improve criminal justice liaison

CWP Forensics department have teamed up with the *National Autistic Society* (*NAS*) to improve screening for autism at Cheshire's custody suites and prevent those with learning difficulties from re-offending. The partnership plans to implement screening measures whereby everyone who enters the custody process is assessed for autism using a tailored questionnaire. Individuals who require support will then be referred to the relevant team. CWP Special Forensic Lead, Gordon Leonard (pictured left) said:

"It's all about identifying autism at the earliest opportunity, so that adjustments can be put in place to support people during their time within th criminal justice system".

Specialist community mental health service to support new and expectant mums across Cheshire and Merseyside

Dr Tania Stanway was supported by the CWP Effective Services Department and other mental health trust partners to secure more than £3million of *NHS England* funding to develop a Specialist Perinatal Community Mental Health Service. The service will be delivered through three locality teams provided by CWP, *5 Boroughs Partnership NHS Foundation Trust* and *Mersey Care NHS Foundation Trust*, and will support women with serious mental health problems during pregnancy and in the first year after birth. The funding from the Perinatal Mental Health Community Services Development Fund is the first successful bid for the Cheshire and Merseyside Sustainability and Transformation Plan (STP) footprint. The perinatal development fund, set up by *NHS England*, is part of a £365million plan to expand perinatal support to an extra 30,000 women a year by 2020.

Women are more likely to suffer from mental health issues during the perinatal period than at any other point in their lives. Securing this funding has provided CWP and its partner trusts with the opportunity to greatly improve access to evidence-based treatments, as well as training for other front-line services caring for local women. It will improve early intervention in perinatal mental health care to prevent local women and their children from experiencing potential problems in the future and build capacity and sustainability across the workforce to ensure consistent, high-quality care across the region.

Thousands of women from across Cheshire and Merseyside will benefit from the additional funding. Rebecca Brook, a teacher from Macclesfield (pictured with her daughter, above), was diagnosed with depression shortly after giving birth to daughter Eleanor last year; she said:

"I struggled to breastfeed when Eleanor was first born. This made me feel like I had failed as a mother, which led to strong feelings of depression and anxiety. I knew about the dangers of mental health to women during the perinatal period, but I never realised just how bad it makes women feel. I was lucky to have such fantastic support from my Health Visitor, as well as local mothering group, SMILE. However, I understand that some people aren't so lucky. The funding announcement is brilliant news as I'm sure it can really help to change stigma around perinatal mental health and provide consistent levels of support to local women."

Introduction to Improvement Training

As part of CWP's approach to continuous improvement, the Effective Services Department has started to deliver improvement training to staff. The training aims to introduce or refresh our workforce's improvement skills and raise awareness of CWP's approach to continuous improvement. The course is delivered in partnership with *Advancing Quality Alliance* (*AQuA*), a North West NHS health and care quality improvement organisation which CWP are members of.

AQuA
Advancing Quality Alliance

Safieh Fraser, Service Improvement Manager, and Andy Hayward, Service Improvement Officer, completed *AQuA*'s level 3 Advanced Improvement Practitioner Programme in 2015. They have worked with *AQuA* to deliver two cohorts of their level 1 Introduction to Improvement training to 35 members of staff.

At the end of the course, trainees complete a poster, sharing the improvement methods they have used to improve their service and contribute to building evidence of continuous improvement. Examples of posters from the training will be shared in the next edition of the Quality Improvement Report. For more information, please contact Andy Hayward on 01244 397391.

Programme Management Office

The Effective Services Department now has responsibility for the Trust's *Project Management Office* role, covering the Trust's key priority projects. These projects all reflect Trust developments aiming to improve effectiveness and quality of services.

The Trust five key priority projects are:

- Redesign of services in East and Central Cheshire, this is particularly looking at mental health services for adults and older people and will look to invest in community provision.
- West Cheshire community physical health services' financial recovery plan.
- CAMHS Tier 4 redesign, focusing on movement of clinical services to Ancora House and the imminent *NHS England* tender process.
- West Cheshire 0-19 years services, looking to improve effectiveness in readiness for a tender opportunity.
- Learning Disability transformation aimed at transforming services for people of all ages with a learning disability and/ or autism.

For more information contact Tracey Collins, Head of Effective Services, tracey.collins@cwp.nhs.uk

Patient Experience News and *patient feedback*

Patient Experience priority for 2016/17 – Achieve a continuous improvement in people's experience of healthcare by promoting the highest standards of caring through implementation of the Trust's person-centred framework

High quality standards of care and facilities for CWP patients

Patient-led assessments of the care environment (PLACE) are a self-assessment of non-clinical services which contribute to healthcare delivered in both the NHS and independent healthcare sector in England. Through focusing on the areas which matter to patients, families and carers, the PLACE programme aims to promote a range of principles including:

- Putting patients first
- Actively encouraging feedback from the public, patients and staff to help improve services
- Striving to get the basics of quality of care right
- A commitment to ensure that services are provided in a clean and safe environment that is fit for purpose

The PLACE results for 2016 were released in August and are detailed in the table below. The results demonstrate that:

- CWP scores have improved from previous visits
- CWP is above national average on all areas of inspection

Area of assessment	Cleanliness	Food	Privacy, Dignity and Wellbeing	Condition, Appearance and Maintenance	Dementia	Disability
CWP	99%	92%	92%	97%	95%	89%
National	98%	88%	84%	93%	75%	79%

Wards sign up to a national dementia campaign

Three older people's wards at CWP have signed up to a national campaign to enable the families and carers of patients with dementia to stay with them in hospital. *John's Campaign* is named after Dr John Gerrard who passed away from Alzheimer's disease in 2014. Meadowbank, Croft and Cherry wards have all pledged their support to the campaign after recognising the important role that families and carers play in putting people with dementia at ease during their hospital stay, demonstrating their commitment to person-centred care.

Christine Turnbull (pictured above), said:

"Cherry ward pledges to build on our approach to welcoming relatives and carers to the ward regardless of the time of day. We will recognise relatives and carers as more than visitors and will support and enable them to be as involved as they wish to be in their loved one's care."

John's campaign

'We are calling for the families and carers of people with dementia to have the same rights as the parents of sick children, and be allowed to remain with them in hospital for as many hours as they are needed, and as they are able to give. Caring can be an exhausting business – we are asking only for the RIGHT for carers to continue to care, not the DUTY.'

www.johnscampaign.org.uk

Maurice Egan, ward manager (pictured below left), added "On Croft ward we are committed to supporting carers and recognise them as full partners in their loved one's care from first contact. We want to ensure that carers receive empowering support, and continue to inform decisions as expert partners in care."

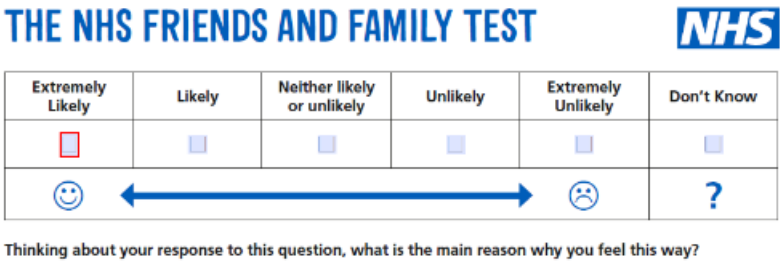
CWP believes support from family or other carers is essential for anyone to live well with dementia and it makes no sense to impose limits on this support during the stressful and disorientating experience of a hospital admission. *John's campaign* is supported by national newspapers, the Chief Nursing Officers of England, Scotland, Wales and Northern Ireland, the Alzheimer's Society, Patient Opinion and carers organisations. It has also received clear political support.

Tracey Myers, ward manager on Meadowbank ward in Wirral, said: "We are committed to including carers in supporting their loved ones from the moment of admission to our ward. We encourage their contribution and expertise in providing person-centred care for their family."

The pledge for support comes after the Trust had an article published in the Guardian Newspaper about 'John's Campaign' and the importance of person-centredness in delivering balanced care.

Friends and Family Test

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way for patient to give their views after receiving care or treatment across the NHS.



Since its launch in 2013, more than 25 million pieces of patient feedback have been submitted. The FFT has been rolled out across most NHS services, including community care, hospitals, mental health services, maternity services, GP and dental practices, emergency care, patient transport and more.

Goal driven measure for patient experience

CWP has set itself the target to increase uptake of the Friends and Family Test each quarter. The aim is to improve Trustwide uptake by 10% or better by March 2017. Overall results for April to December 2016 show that 2,646 CWP patients have responded, of whom 78.6% were extremely likely, or likely, to recommend the service. The PALS (Patient Advice and Liaison Service) Officer and Voluntary Service Lead have visited the wards to discuss with the ward managers and the occupational therapists how to improve the response rate for FFT. The PALS team will monitor on a monthly basis the percentage of FFT responses versus discharges to identify gaps and where wards need support with implementing FFT. An exercise to support the community teams with FFT will be undertaken in the New Year.

Crisis and Reablement team celebrate training achievement

Eight members of the Crisis and Reablement team have now successfully completed the Care Certificate. The team comprises fourteen Community Health Support workers, many of whom are part-time, and this achievement represents a significant proportion of the team.

The team provides assistance to patients in their own homes who have a new health crisis and are at risk of hospital admission. The team also supports the work of the District Nurses by supporting patients who have a palliative diagnosis and are often in the final days of life. Care for these patients must be of the highest standard in order to fulfil their wishes of a preferred place of care which is home.

Completing the Care Certificate has helped the team focus on the core values of the Trust and the ethical and moral values of the team. The team receives a high level of compliments, and in their Friends and Family test results 100% of respondents were extremely likely to recommend the service.

Pictured above with her team Sue McGuigan, team manager said:

> "Although the Care Certificate does require an amount of time and effort to ensure that all of the elements are addressed and assessed, this time has been instrumental in building the relationships of staff with their colleagues and managers and contributes to the overall spirit of the team and in turn the standards of care set and maintained".

Developing the Person-centred Framework

CWP's Person-centred Framework is a new set of overarching principles that will ensure that person-centred thinking runs through everything we do.

The initial principles were designed in partnership with people who access our services, involvement representatives, volunteers, staff and members of the public. A workshop was held in October to start to populate the framework with person centred approaches and tools. The framework is planned to launch in January 2017.

Person-centred care "takes into account service users' needs, preferences and strengths. People who use mental health services should have the opportunity to make informed decisions about their care and treatment, in partnership with their health and social care practitioners." (NICE Guidance CG136)

Between August and November 2016, CWP formally received 972 ***compliments*** from people accessing the Trust's services, and others, about their experience of the Trust's services. Below is a selection of the comments and compliments received:

Learning Disability Services – CWP East
Parents wanted to thank staff for the support given over the years to their child accessing respite services. They said the staff have worked in a person centred way, maintained independence and it was a great relief to them that their child was settled when accessing respite, they said this has enabled their child to remain at home for all these years – all have done a fantastic job!

Early Intervention Team – CWP Wirral
"This email is just a simple 'thank you' and a showing of my deepest respect to you and your staff, i.e. the early intervention team, the home treatment team, the doctors, the nurses, the cognitive behavioural therapist and anyone else who has had anything to do with improving the wellbeing of my mental health."

Physical Health – CWP West
"Delighted with the extended hours service, particularly (member of staff) who is the nurse that dealt with us. We have been attending for several weeks and felt the service we received was fantastic. Nothing was too much trouble for (staff member)."

West Cheshire IAPT – CWP West
"I had a very positive experience with CBT – I have learned a lot and feel I am looking forward to the future. The time taken and breadth of material covered with (member of staff) shows how much importance she gives to her clients to ensure they have maximum return so they can help themselves in the future. Thanks so much."

CAMHS
"I just wanted to let you know that I liked today's appointment, it made me feel more relaxed and less anxious."

Share your stories

We welcome your best practice stories and Quality Improvement successes; please share your work via the Safe Services Department using the Best Practice and Outcomes page on the intranet or contact the Healthcare Quality Improvement Team on 01244 393138

Look out for more about Quality Improvement in Edition 3 of the *Quality Improvement Report*

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NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	The CWP Zero Harm approach to quality – annual review and forward plan of developmental areas
Agenda ref. no:	16/17/112
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and Approval
Date of meeting:	25/01/2017
Presented by:	David Wood, Associate Director of Safe Services

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
N/A	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy CWP policies – policy code FR1	No
N/A	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*

The Trust's approach to quality, its Zero Harm aspirations, is about ensuring that there is a focus on continuous improvement in the delivery of patient safety, effective and person-centred care that results in a positive experience. The Board of Directors endorsed and invested in this approach in 2014. An update report against an operational implementation plan is reviewed at each meeting of the Quality Committee to ensure sound progress against the Trust's quality goals. This progress demonstrates a number of positive achievements, suggesting that the Trust's aspiration to continuously improve the quality of care by tackling unwarranted risks and variation is being realised. This is being tackled robustly through two significant initiatives that have been introduced in the past year: (i) patient safety improvement reviews at team level, and (ii) a learning themes quality improvement project. The presentation to the Board of Directors today discusses these initiatives and explores a number of areas of focus and development for the year ahead.

Background – *contextual and background information pertinent to the situation/ purpose of the report*

The Board of Directors approved a forward strategy in 2014, committing to an aspiration of continuously improving the quality of care by tackling unwarranted risks and variation. This was in response to the Berwick root-and-branch review of patient safety, which found that most healthcare organisations had little capacity to analyse, monitor or learn from safety and quality information. In addition to an annual review at the Board of Directors, each Quality Committee receives updates against the implementation plan for the forward strategy.

Assessment – *analysis and considerations of options and risks*

Quality and safety performance has been reported through a number of routes during the previous year, including the Quality Improvement report, Learning from Experience report and locality data packs.

Highlights demonstrable of positive progress towards the Trust's long-term quality aspirations include:

- Continuous improvements to no harm incident reporting over the last four months: 84% of all incidents compared to 83% of all incidents in the previous four month period (safety).
- Sustained improvements to effective pressure care management, with increasingly long runs without an avoidable pressure ulcer being identified: from June to-date there have been zero reported (effectiveness).
- Performance against activities which impact on patient experience of care have continuously improved, as demonstrated through the PLACE assessment process, including delivery of care which promotes privacy, dignity and wellbeing has improved from 90% in 2015 to 92% in 2016 [84% nationally]; and meeting the needs of people with dementia has improved from 78% to 95% [75% nationally] (experience).

Areas where further focused attention is required include:

- An aim to reduce the number of recurrent learning themes arising from serious incident investigations, facilitated by quality improvement actions identified by the Trustwide learning themes project (safety).
- Development of clear outcome measures, particularly in community mental and physical health services, reported through locality data packs to identify continuous improvements to care delivery (effectiveness).
- A focus on continuously improving the number of formal compliments received in order to apply learning from examples of excellent care (experience).

As detailed in the presentation being received at today's meeting of the Board of Directors, areas of focus for the forward year of this strategy include:

1. Simplicity of vision to enable quality improvement (safety)

Promoting the simplicity of the Zero Harm message will help people to connect with the strategy, enable safety critical behaviour, and encourage robust quality improvement efforts.

2. Stimulation of creativity in order to deliver better outcomes (effectiveness)

Risk management systems can stifle innovation; the simpler and less obtrusive they are supports creativity, which is core to identifying best practice and driving innovation.

3. Develop learning agility (experience)

Promote the ability and willingness to learn from experience, to apply learning, and to "unlearn", in order to be responsive to people's needs so that they experience person-centred care.

Overall, the Trust remains on track with its long-term quality aspirations and now requires re-calibration to ensure ongoing success. Key to the continuing success of the Trust's aspirations will be ensuring a renewed focus on continuous quality improvement. The Quality Committee, in its role for ensuring that that the strategic priorities for quality improvement are identified, implemented and monitored, is ensuring that, through its agenda, it is starting to look at quality in more detail to better demonstrate where real improvements are being made, with the aspiration to achieve safe, effective, person-centred and equitable care through quality improvement.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*

To **discuss** and **note** the highlights provided in this annual review and **endorse** the suggested developmental areas identified for the Zero Harm forward quality strategy.

Who/ which group has approved this report for receipt at the above meeting?		Board of Directors – business cycle requirement
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	Board of Directors	18/01/2017

Appendices provided for reference and to give supporting/ contextual information:	
Appendix number	Appendix title
N/A	N/A

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Person Centred Framework Update
Agenda ref. no:	16/17/113
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	25/01/2017
Presented by:	Rebecca Burke-Sharples, Non-Executive Director

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	No
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
35T	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
35T	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*
This report describes the continuing development of the Person Centred Framework. It summarises the consultation on the Person Centred overarching Principles, and describes the development of the Person Centred underpinning tools and approaches.

Background – *contextual and background information pertinent to the situation/ purpose of the report*

On Tuesday 18 October 2016, a workshop was held to begin the process of capturing the underpinning Tools and Approaches. It included the chance for people to make pledges on how they would take the Person Centred Framework forward in the future. The November CELF session was given over to the Tools and Approaches which focused on identifying key tools and approaches and clarifying next steps for building the Person Centred Framework. On Monday 28 November, a meeting brought together representatives from the Patient and Carer Experience, People and Organisational Development and Patient Safety and Effectiveness Sub Committees to agree the first set of Tools and Approaches. The meeting was reminded that the Person Centred Framework will continue to develop and it will remain a living document, regularly updated and refreshed. The meeting agreed the first list of tools and approaches. The meeting confirmed that each tool and approach (see Appendix 1) will have both a description and a corresponding link to related web based resources. The current position is that a designated person is being identified to lead on the development of each tool and approach's description and web resources. This will allow for the Framework to remain relevant and up to date.

Assessment – *analysis and considerations of options and risks*

Following the joint meeting of PACE, POD and PSESC, the Person Centred Framework Design Group met to discuss next steps. The meeting agreed that the 5 tools and approaches to work up and spend time on in the first year will be; Person centred thinking, Helping people be the best that they can be (including coaching), Self-care, Shared decision making, and Effective care planning. The Design Group confirmed that there will be a week set aside for the launch of the Framework. This will be the week beginning 6 March 2017.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*

The Board of Directors is recommended to **approve** the Person Centred Framework Overarching Principles, tools and approaches and note the date of the launch event.

Who/ which group has approved this report for receipt at the above meeting?	Avril Devaney, Director of Nursing, Therapies and Patient Partnership
Contributing authors:	Liz Matthews, Associate Director of Patient and Carer Experience

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Patient and Carer Experience Sub Committee	January 2017

Appendices provided for reference and to give supporting/ contextual information:
Provide only necessary detail, do not embed appendices, provide as separate reports

Appendix no.	Appendix title
Appendix 1	Person Centred Framework Update
Appendix 2	Overarching Principles
Appendix 3	Tools and Approaches

16_17_113 Appendix 1

Person Centred Framework Update

Introduction

This report describes the continuing development of the Person Centred Framework. It summarises the consultation on the Person Centred overarching Principles, and describes the development of the Person Centred underpinning tools and approaches.

The person centred Framework overarching principles

The Person Centred Framework Overarching Principles have been distributed and shared widely, both within CWP and also to its partners. Feedback has been encouraged in a number of different ways, including collecting feedback at team meetings, through a dedicated email inbox and by contacting our external partners, including Directors of Nursing, community partners and consulting with our volunteers. The feedback has been very positive. Comments include:

- “Thank you, it is so important for the Framework to be for everyone, not only people who access services and their carers but also staff”
- "The only feedback I have is to say how important respect is"
- “This is an example of best practice that I think needs to be shared with the CQC"

We have taken on board feedback and the latest draft of the Principles is below:

1. We are all unique, with our own strengths, needs and aspirations. We know that everyone has different abilities and that we all have something to offer. We will respect and nurture different experiences and viewpoints.

2. We will all support and encourage each other to live full lives.

3. Mental health and physical health are as important as each other. We will work together to make informed decisions that can help make life the best it can be, even in times of difficulty.

4. We will celebrate our achievements and learn from everything we do, and we will have the courage to speak up and voice our views. We will always try to improve things to make a lasting difference.

5. We will be honest, realistic and clear with one another about our roles, using language that we all understand.

6. It is important for us to know what matters to each person we meet. We will be adaptable in our approach, working in partnership to provide care which, as far as possible, takes into account each person’s preferences.

7. We will try to understand each person’s situation, encouraging and supporting informed decision-making. We will, when possible, give everyone the choice of when to invite others to act on their behalf.

8. We will work with everyone's strengths, abilities and those things we may not be so good at, to work together to achieve our goals, taking time to celebrate the good things we do.

The Person Centred Framework Underpinning Tools and Approaches

On Tuesday 18 October 2016, a workshop was held to begin the process of capturing the underpinning Tools and Approaches. As with the first workshop, a mixture of CWP colleagues from all areas of the Trust was joined by involvement representatives. The day was interactive and provided the opportunity for people to make pledges on how they would take the Person Centred Framework forward in the future.

Building on this successful day, the November Clinical Engagement Leadership Forum session was given over to the Tools and Approaches. It focused on identifying key tools and approaches and clarifying next steps for building the Person Centred Framework.

To make sure that the views of people with lived experience have fully been taken into account, an exercise was undertaken to telephone all involvement representatives who attended the June and October workshops. These telephone conversations gave the opportunity for further suggestions of tools and approaches to be captured.

On Monday 28 November, a meeting brought together representatives from the Patient and Carer Experience, People and Organisational Development and Patient Safety and Effectiveness Sub Committees to agree the first set of Tools and Approaches. The meeting was reminded that the Person Centred Framework will continue to develop and it will remain a living document, regularly updated and refreshed.

The meeting agreed the first list of tools and approaches. The meeting confirmed that each tool and approach will have both a description and a corresponding link to related web based resources. The current position is that a designated person is being identified to lead on the development of each tool and approach's description and web resources. This will allow for the Framework to remain accurate and up to date. The current list of tools and approaches is reproduced below.

Tools

- Wellness Recovery Action Plan (WRAP)
- Values Based Recruitment
- Leading Change, Adding Value
- One Page Profiles
- Person-Centred Thinking
- Solution Focused (brief) Therapy (SFBT)
- Life Story
- This is me
- Shared Decision Making

- Next Step Cards
- Care Planning
- Advance Statements

Approaches

- John's Campaign
- Real-time feedback
- Helping People Be The Best They Can Be
- Recovery Colleges
- Dementia Friends
- Co-production
- Patient Letters
- Self-care
- Peer Support
- Easy Read

Implementation of the Person Centred Framework

Straight after the joint meeting of PACE, POD and PSESC, the Person Centred Framework Design Group met to discuss next steps. The meeting agreed that the 5 tools and approaches to work up on spend time on in the first year will be:

1. Person centred thinking

2. Helping people be the best that they can be (including coaching)

3. Self-care

4. Shared decision making

5. Effective care planning

The group also agreed that a workshop will be held in early 2017 to discuss in greater detail next steps for the launch and implementation of the Person Centred Framework. These discussions will include how the Framework will become embedded at CWP.

The Design Group confirmed that there will be a week set aside for the launch of the Framework. This will be the week beginning 6 March 2017.

Liz Matthews December 2016

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Overarching Principles for the Person Centred Framework

1. We are all unique, with our own strengths, needs and aspirations. We know that everyone has different abilities and that we all have something to offer. We will respect and nurture different experiences and viewpoints.

2. We will all support and encourage each other to live full lives.

3. Mental health and physical health are as important as each other. We will work together to make informed decisions that can help make life the best it can be, even in times of difficulty.

4. We will celebrate our achievements and learn from everything we do, and we will have the courage to speak up and voice our views. We will always try to improve things to make a lasting difference.

5. We will be honest, realistic and clear with one another about our roles, using language that we all understand.

6. It is important for us to know what matters to each person we meet. We will be adaptable in our approach, working in partnership to provide care which, as far as possible, takes into account each person's preferences.

7. We will try to understand each person's situation, encouraging and supporting informed decision-making. We will, when possible, give everyone the choice of when to invite others to act on their behalf.

8. We will work with everyone's strengths, abilities and those things we may not be so good at, to work together to achieve our goals, taking time to celebrate the good things we do.

Cheshire and Wirral Partnership NHS
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STANDARDISED REPORT COMMUNICATION

Report subject:	Update on the continuous improvement plan in response to the Southern Health independent report recommendations and response to the CQC report "Learning, candour and accountability"
Agenda ref. no:	16/17/114
Report to (meeting):	Board of Directors – meeting in public
Action required:	Comments and/ or recommendations sought
Date of meeting:	25/01/2017
Presented by:	Avril Devaney – Director of Nursing, Therapies and Patient Partnership

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	No
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
N/A	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	Yes
Serious incident management risk is in-scope to replace former strategic risk	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*
CWP is committed to learning from external recommendations, as an opportunity to strengthen its own systems and processes further. The Board has received routine updates on how the Trust is responding to the learning identified in the independent report into unexpected deaths of people accessing services at Southern Health NHS Foundation Trust over a four year period since April 2011. This reports provides a final update on the Trust's continuous improvement plan in response to that external learning, reviews new learning from the CQC report "Learning, candour and accountability" (which has reviewed how acute, community and mental health trusts across the country investigate and learn from deaths of people who have been in their care) and considers the Trust's current controls and assurances to identify gaps where a quality improvement approach and collaborative work can be undertaken to assure the Board of the robustness of organisational systems and processes for reporting, investigating and learning from serious incidents.

Background – *contextual and background information pertinent to the situation/ purpose of the report*

To gather evidence, the CQC carried out a national survey of all NHS trusts and visited twelve acute, community healthcare and mental health trusts. They engaged with over 100 families, holding interviews and events, as well as seeking views through an online form, their online community and social media. They also consulted with charities and NHS professionals. The CQC focused on five key areas. **1. Involvement of families and carers.** They found that families and carers often had a poor experience of reviews and investigations and were not always treated with kindness, respect and sensitivity. **2. Identification and reporting.** The CQC found inconsistency in the way organisations become aware of the deaths of people in their care. **3. Decision to review or investigate.** The CQC found that Trusts tended to investigate only those deaths linked to serious incidents. **4. Reviews and investigations.** The CQC found the quality of investigations was often poor and methods set out in the NHS England Serious Incident Framework were not applied consistently. **5. Governance and learning.** The CQC found that there were no consistent frameworks or guidance requiring boards to keep all deaths under review. Where investigations did take place, there were no consistent systems to ensure recommendations were acted on or learning shared. There was also a lack of robust mechanisms to disseminate learning from investigations or benchmark beyond a single trust.

Assessment – *analysis and considerations of options and risks*

The Head of Clinical Governance has reviewed the current continuous improvement plan in response to the Southern Health independent report recommendations. There are recommendations for actions to be closed where the work is either completed or is embedded into ongoing work programmes for the Safe Services Department. Where actions remain open, it is suggested that these are themed and developed into a new quality improvement framework, which will incorporate the recommendations from the national CQC report. Many of the recommendations are for national agencies to develop improved processes to support trusts. However, there are areas that CWP can explore further to develop the work already commenced. These will include:

- Continually review and improve how the Trust can learn from deaths and not only those which are thought to be as a result of a serious incident, thus avoiding missing opportunities to improve care.
- Improve how we support and involve bereaved relatives and carers to ensure that they receive an honest and caring response and they are meaningfully involved throughout the process.
- Work with the CCGs and other healthcare providers to ensure we develop a consistent approach to identifying and reporting the deaths of people accessing care services and sharing of this information with other services involved in a patient's care.

It is proposed that a mortality task and finish group be established to consider the above, identify residual gaps requiring quality improvement approaches, which can then be associated with a risk mitigation plan as part of a re-modelled strategic risk that will receive senior oversight by the Quality Committee and the Board of Directors.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*

The Board of Directors is asked to **comment** on the Trust's proposed means of responding to the CQC report "Learning, candour and accountability" and **agree** to the recommendations in Appendix 1.

Who/ which group has approved this report for receipt at the above meeting?		David Wood, Associate Director of Safe Services
Contributing authors:		Audrey Jones; David Wood
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	Board of Directors	18/01/2017

Appendices provided for reference and to give supporting/ contextual information:	
Appendix no.	Appendix title
1	Continuous improvement plan in response to Southern Health independent report recommendations – iteration 4

16_17_114 Appendix 1

Action plan title	Continuous improvement plan in response to Southern Health independent report recommendations
Action plan authors	Audrey Jones, Head of Clinical Governance David Wood, Associate Director of Safe Services
Executive lead	Avril Devaney, Director of Nursing, Therapies & Patient Partnership
Date of development	22 March 2016 (iteration 1)
Date/s of next scheduled reviews	27 July 2016 (iteration 2) 30 November 2016 (iteration 3) 25 January 2017 (iteration 4)

***Theme:* Board Leadership and Oversight**				
Action identified (for Southern Health)		**Current CWP assurance**	**Further improvement actions for CWP**	**Update January 2017**
1a	The Board needs to ensure the processes of reporting and investigating unexpected deaths are consistent and robust throughout the organisation and to improve the quality of investigations and the involvement of families in those investigations. The Trust needs to prioritise the review of deaths as part of a wider mortality review process making better use of data available.	▪ The Board receives oversight of an exception report at each meeting, reporting on all serious incidents. ▪ The Board receives information about deaths via the Learning from Experience report three times per year. ▪ The Executive Team receive notifications of all serious incidents that are reported on the StEIS system on the day that they are reported. ▪ Duty of Candour compliance is recorded and monitored via the Datix system, furthermore, the engagement and involvement with family is checked by the weekly Meeting of Harm.	i. To set up a process for all serious incident reports to be signed off by a review team meeting. This meeting will involve an Executive Director, Non Executive Director, a member from the Safe Services Department, the Investigation Manager and one other Director/ Clinical Director. Pilots to take place in March 2016, the full meeting to commence April 2016. ii. Head of Clinical Governance to undertake an audit in relation to compliance with Duty of Candour by 15 April 2016.	i. Review meeting commenced March 2016 as a pilot. Terms of reference reviewed and updated post pilot. Positive feedback has been offered by the Non Executive Directors and by the Investigating Managers who have attended. The meetings will continue on a weekly basis. **Completed/ ongoing.** ii. A detailed audit was presented to Quality Committee on 7 September 2016. Recommendations identified are being taken

		Further, involvement is captured within the final investigation report. ▪ Incident investigator training includes coverage on the duty of candour and involving families in investigations. ▪ The Trust is appointing a Clinical Champion to support the Trust in improving the quality of investigations, action planning and embedding the learning from incidents.	iii. A toolkit to support a consistent approach to all "serious" investigations (including HR and safeguarding) is currently being developed by the Heads of Clinical Governance, Safeguarding and Human Resources, for completion end April 2016.	forward as part of the Learning from Experience report. **Completed.** iii. Heads of Clinical Governance, Safeguarding and Human Resources have established a toolkit. Work will be ongoing to ensure it remains live, iterative and a valuable, enabling resource for staff. **Completed/ ongoing.**
1b	The Board needs to understand and make full use of the data available and the underlying information required for assurance that unexpected deaths are being properly identified and investigated.	As 1a.	i. Discussion and agreement, on an ongoing basis and upon receipt of the routine Learning from Experience report, regarding what information the Board wishes to/ should receive.	i. As 1a.
2a	2015/16 Annual Report should provide a more transparent breakdown of deaths including an analysis of the themes that occur for people with Mental Health and Learning Disability challenges.	The Trust's Annual Report and Quality Account contains high level data which currently meets the national reporting requirements and guidance.	i. The Annual Report/ Quality Account 2015/16 will be developed to include a detailed breakdown of deaths and analysis of the mortality thematic reviews that have been undertaken.	i. The mandatory sections of these reports contained information on learning from serious incidents and also inquests. The ongoing Learning from Experience report will continue to include analysis of themes. **Completed/ ongoing.**
2b	Provide data on all deaths of people using a Mental Health or Learning Disability service including service users of the social care service.	▪ All Learning Disability deaths are reported within Datix, a 72 hour safety review on all deaths is submitted to the weekly Meeting of Harm. This meeting identifies the requirement for any further investigation. ▪ As 1a.	No further actions currently.	*Learning Disability services* The Learning Disability mortality review programme in place since September 2016. Medical Director and Learning Disability Services Consultant Nurse have agreed to meet ahead of March 2017 Quality

				Committee to agree ongoing governance arrangements. *All other Mental Health services* Deaths known to CWP to be identified by using a stratified sample of these deaths. The mortality task and finish group to agree review methodology. **Transfer action to quality improvement programme for learning, candour and accountability.**
2c	Outline how many unexpected deaths there have been and in which areas.	The Board receives the number and detail of unexpected deaths which are to be investigated in line with the Trust's serious incidents policy.	As 1bi.	As 1bi.
2d	Outline how many IMAs (equivalent to CWP 72 hour safety review) have been written as a result and how many have progressed to CIR (Critical Incident Review) and then onto being a Serious Incident under the 2015 Serious Incident Framework.	Unexpected deaths are discussed at the weekly Meeting of Harm. A decision is made as to the level of investigation that is required after reviewing the 72 hour safety review. The decisions of the meeting are captured on a spreadsheet, recorded on Datix and where appropriate StEIS is updated.	i. A report broken down by specialty will be produced to provide the Board with a summary of unexpected deaths occurring, the numbers requiring further investigations, and those not requiring further investigations. This will accompany the exception report received by Board (assurance 1a).	i. This is an appendix to the current exception report. **Completed.**
2e	Include a summary of how many deaths are 'pending' for the purposes of investigation with a reason why. This would make the decision-making more transparent as regards to delays in reporting to StEIS.	This is currently discussed and recorded at the weekly Meeting of Harm. This information is currently available within the Datix system.	i. The current report produced following the weekly Meeting of Harm is being developed on an ongoing basis to demonstrate transparency of decision making processes.	i. A record of the decisions is completed usually 24 hours after each meeting to record this in support of transparency of decision-making. **Completed/ ongoing.**

2f	Provide information to enable trends to be identified and for Board members to become familiar with the information.	Improved reporting of serious incidents and deaths has been incorporated into the exception report provided to the Board.	i. Ongoing work to enhance information provided in the Learning from Experience Report in relation to incidents, unexpected deaths, trends and learning themes.	i. **Completed/ ongoing.**
2g	Provide information which includes the categorisation of all deaths reported to Datix.	As 1a.	As 1a.	As 1a.
2h	Provide data at least twice a year on all deaths. Themes should be reported on which covers at least the previous 6 quarters (or a sufficient number to provide a reasonable sample from which to identify themes). This is particularly important for the Learning Disability arena where numbers of deaths in each quarter will be low and in areas that may not be considered to meet Serious Incident reporting guidance e.g. non-suicide Mental Health deaths.	The Learning from Experience report contains the previous 3 trimesters for all deaths, including Learning Disability Services. The recommendations and findings from serious incidents are themed.	No further actions currently.	**Completed/ ongoing.**
2i	There is clear national and Trust policy guidance on reporting and investigating deaths. Trust policy includes a full set of templates and processes – the Board should ensure these policies are being followed and templates being used.	Policy and procedures are in place and specifically relate to reporting and investigating incidents and deaths. The Trust policy is in line with the NHS England framework. An investigation toolkit is currently being developed in partnership between the Safe Services, Human Resources and Safeguarding Departments.	i. As 1aiii. ii. Compliance against Trust policy to be provided to the Quality Committee on an annual basis, commencing September 2016.	i. As 1aiii. ii. The national CQC report has identified recommendations. **Transfer action to quality improvement programme for learning, candour and accountability.**
Theme: **Monitoring mortality and unexpected deaths/ attrition**				

3	Unexpected deaths should be defined more clearly. We suggest the Trust uses, as a starting point, the classification outlined in this report to identify the potential need for review or investigation in each case. In particular, the definition of an 'unexpected death' needs to be refined to be more applicable to the circumstances of people with a Learning Disability regardless of setting.	The Trust's weekly Meeting of Harm monitors all unexpected deaths. A 72 hour safety review is presented by the locality and the meeting makes a decision as to the level of investigation that is required. If a decision is made not to undertake any further investigation – this will be discussed and agreed with the relevant CCG. All decisions are recorded within a spreadsheet and recorded after every meeting onto the Datix system.	i. The Trust's incident reporting and management policy will be updated immediately to include a definition of an unexpected death to incorporate the recommendations.	i. The national CQC report has identified recommendations. **Transfer action to quality improvement programme for learning, candour and accountability.**
4	The Trust should develop a Mental Health and Learning Disability Mortality Review Group which includes reviewing unexpected deaths which do not constitute a serious incident. Clear terms of reference should be developed. This group should serve a number of purposes: a. to provide oversight of all deaths occurring amongst the Trust's Mental Health and Learning Disability service users b. develop a mortality dashboard which is provided to stakeholders and reported in the annual report, that provides a full picture of all deaths, themes, CIRs and serious incidents c. monitor causes of deaths amongst its service users by using the 2013/14 MHMDS data release to see if the ICD 10	The Trust currently works with acute trusts with some joint investigations as a result of serious incidents.	i. This will be considered further as part of the iterative development of the joint improvement plan with all the Trust's quality leads from the CCGs and will be revisited/ completed pending further guidance from NHS England.	i. The national CQC report has identified recommendations. **Transfer action to quality improvement programme for learning, candour and accountability.**

	chapters show any trend d. provide an evidence base to share with Local Authority commissioners and other providers highlighting themes that are arising relating to social care and other agencies issues e. to ensure that liaison with acute provider colleagues can take place at a clinical and managerial level where the Trust has concerns raised with it about care in acute settings should include a GP as part of its membership g. the formation and progress of this new group should be monitored at Board level h. the group must aim to improve the transparency of reporting levels of unexpected deaths in these service user groups.			
			Theme: **Thematic Reviews**	
5	A template for a thematic review should be produced. All thematic reviews should be undertaken in an agreed format which meets best practice standards and includes follow up, evaluation and demonstration of lessons learned and practice change.	The Trust currently uses a format for thematic reviews.	No further actions currently.	As 1aiii.
6	There should be further work undertaken to establish whether all deaths of people over the age of 65 are being appropriately reported and investigated – in	Reporting of deaths takes place via Datix. As stated previously, these reported deaths are then discussed at weekly Meeting of Harm.	No further actions currently.	As 2b.

	particular amongst inpatients.			
7	The Trust should provide staff with regular training and guidance to help them manage physical health conditions of long-term mental health service users. Diabetes management stands out as an area for greater awareness from a number of cases we reviewed.	Physical healthcare training is delivered across the Trust, the delivery and effectiveness is monitored by the physical healthcare clinical network.	i. Physical healthcare clinical network is currently updating its assurance framework to incorporate learning from external organisations and will therefore incorporate this area also.	i. Work continues throughout the Trust to improve the management of physical health in mental health and learning disability patients. This is co-ordinated through the Physical healthcare network and monitored through the Patient Safety & Effectiveness Sub Committee. **Completed/ ongoing.**
8	The Trust should undertake thematic reviews of the issues raised in this report, including: a. Medical input and senior medical oversight b. The role of the care co-ordinator c. The need for pharmacy colleagues to be more explicitly involved in cases involving drug toxicity and polypharmacy.	These were specific issues to Southern Health. CWP identifies themes from serious incident reports and thematic reviews are undertaken when required.	No further actions currently.	**Closed.**
9	A regular review of all sudden deaths of OPMH inpatients should be carried out. This should include a review of whether care treatment decisions are taken quickly enough, whether co- operation and liaison with acute medical staff is adequate and whether staff feel confident in managing and identifying sudden physical deterioration including CPR.	All unexpected deaths within CWP inpatient settings are reported on Datix, with a 72 hour safety/ mortality review undertaken and shared with the weekly Meeting of Harm.	No further actions currently.	**Closed.**
Theme: **Reporting and identifying deaths**				
10	The Trust should review the way	The Trust policy includes guidance	i. Safe Services Department is	i. The initial actions have been

	that deaths are categorised under the incident reporting policy so that: a. All relevant deaths are re-graded accurately before and after investigations have taken place. b. All relevant deaths are reported on regardless of impact grading to ensure that deaths have greater prominence in the Trust's reporting systems. c. Accurate information is provided for future Trust Mortality Reviews. d. That immediate work with the NRLS team is undertaken to ensure the changes to the local risk management system map as expected to NRLS and on to CQC.	on categorisation of incidents. Deaths are graded by the reporter and quality assured by the manager, overseen by the Safe Services Department.	currently working through an action plan to improve the quality of reporting and data completion in relation to incident reporting, in partnership with the NRLS. This is due to be completed during the course of quarter 1 of 2016/17.	completed. The incidents team revisits the incident once the outcome of the inquest is known to ensure accurate mortality data. Further, the incidents team is now working to a programme of data quality improvement which is ongoing throughout 2016/17 – this includes migrating complaints, claims, legal and inquests into one platform. This allows a whole system governance approach which will further support a case management approach and facilitate better analysis of trends. **Completed/ ongoing.**
11	The Serious Incident investigation process needs a major overhaul in the Trust. a. Separation of people responsible for quality assurance and those undertaking investigations. This would enable training in review processes and quality assurance to be targeted at senior staff and in investigation techniques at a dedicated group of investigators. b. Quality assurance processes including independent review and sign off. c. Achieving high professional standards in written presentation. d. Timeliness of investigations.	▪ Bank investigators are currently being recruited. ▪ Improved training and support for investigating managers has been implemented. ▪ Corporate and Executive oversight by newly formed investigation review meetings taking place every two weeks. ▪ Independent review is achieved through CCG closure panels' scrutiny. The employment of a Clinical Champion for investigations.	No further actions currently (further actions pending feedback from the pilot of the investigation review meetings).	Bank investigators have been recruited and have commenced investigations. Further training has been organised and delivered, with workshops targeting specific aspects of undertaking investigations. Review meetings have been set up since April (as 1ai). CCGs continue to oversee (via secondary governance) the investigations of CWP through their own closure panels. Clinical services and the incidents team engage with feedback offered and act on

				feedback which is appropriate. The Clinical Champion role is now in place and is initially supporting a cluster review of deaths. **Completed/ ongoing.**
12	Reporting to StEIS should be undertaken within the 2 working days of notification as required by the national guidance.	The Trust is compliant of reporting to StEIS within 2 days of knowing that an incident is a serious incident.	No further action currently.	**Completed/ ongoing.**
13	There should be more explicit action to commence investigations promptly even when a coroner conclusion is not immediately available unless there is a specific reason to delay; any delay should have senior sign off.	The death reporting and incident procedure is specific that delays do not occur in reporting or commencing an investigation unless there is a specific and recorded reason for doing so.	No further action currently.	**Completed/ ongoing.**
Theme: **Involvement of families**				
14	The involvement of families in investigations requires improvement. In particular, improvements are needed in: a. developing clear guidelines for staff, including expected timescales and core standards, which recognise the need for iterative engagement when the family is ready b. ensuring that the investigation process is clearly defined and separate from the support and assistance offered by local treatment teams c. the Trust should ensure that investigators talk to families as early as possible in the process to	The Trust has clear guidance in place, compliance is checked at the weekly Meeting of Harm and is included in the investigation report. An audit is currently underway to establish if there are any gaps in relation to these points. This will be completed, with an action plan, by April 2016 and reported in the Learning from Experience report (see 1aii). The Trust has a system and process for allocating a Family Liaison role which is instigated as soon as the Trust is aware of an unexpected death.	i. The audit for Duty of Candour which is due April 2016 and will be undertaken twice a year will incorporate the recommendations for involvement of families. An action plan will be developed to address any gaps.	As 1aii.

	identify any concerns and take these into account in the ensuing investigation d. provide reports to coroners in time for inquests e. explicitly demonstrating why families are not involved identifying next of kin details for all service users as part of a core assessment including where consent to share has not been provided to enable investigators to find relatives more easily f. working with primary care to identify family members g. where the Trust delays the commencement of an investigation due to inquests or other investigations this should be made explicit to families and the reasons explained h. the performance of divisions in involving families and securing feedback.			
		Theme: **Multi-agency Working**		
15	The Trust Board should seek co-operation with other providers and commissioners to agree a framework for investigations in preparation for future incidents regarding escalation. Divisions should then apply this framework where the incident report suggests another organisation should review or investigate the circumstances of a death.	Collaborative working is being developed and considered within the Terms of Reference within investigations. This includes acute trusts, CCGs and GPs. This would be extended to include other social, health and voluntary organistions when appropriate.	i. See 4i (no other further actions currently).	i. The Incidents Manager and Head of Clinical Governance attend serious incident meetings across all CCGs. Western Cheshire CCG and CWP are piloting the incorporation of GP significant event analysis into investigations if available and if appropriate. Multi-agency working was also discussed at

				the September 2016 meeting of the North West Medical Directors. Further, the CQC national review has identified recommendations in response to this theme. **Transfer action to quality improvement programme for learning, candour and accountability.**
Theme: **Deaths in detention and inpatient deaths**				
16	The Trust should retain a contemporaneous list of all inpatient deaths mapped to Mental Health Act status to enable Trust-wide overview of all inpatient deaths and deaths in detention.	All inpatient deaths of individuals subject to detention under the Mental Health Act are reported and also reported to the CQC.	No further action currently.	**Completed/ ongoing.**
17	All deaths of service users in detention should be investigated, whether expected or not. These investigations should occur regardless of inquest conclusions. This will give assurance that the 24/7 nature of the care required has been of the highest standard. Specific issues addressed in the Terms of Reference for these investigations should include: a. to ensure that physical health care symptoms are not dismissed where challenging behaviour presents; b. that delays in seeking physical health care are not apparent; c. that service users are fully aware of decisions regarding	It is CWP policy to investigate all inpatient deaths of individuals subject to Mental Health Act detention.	i. The Trust's incident reporting and management policy will be updated immediately to incorporate the issues identified in the recommendations. ii. The recommendations will now be included in the training for investigating managers, within the investigatory toolkit and furthermore the new review team for investigations will be informed to consider these.	i. **Completed/ ongoing.** ii. **Completed/ ongoing.**

	whether to treat or investigate chronic or acute symptoms and that these are made in an informed manner; d. that access to full care and treatment is not restricted in any way; e. that staff are adequately supported to provide physical health care and trained to do so.			
		***Theme:* Information management**		
18	The Trust should develop an agreed RiO extract and Ulysses reporting protocol to capture all deaths of Adult Mental Health, Older People Mental Health and Learning Disability service users including community and inpatient locations to form the basis of future mortality review. *(For CWP this is CAREnotes and Datix.)*	▪ The Trust has completed a mortality review for NHS England in March 2016. ▪ The Trust will await further guidance from NHS England as to what process should be in place for all Mental Health trusts (guidance is expected to report on the development of case reviews of most deaths for mental health trusts by 2017).	i. The Safe Services Department will provide a quarterly report on all deaths of Adult Mental Health, Older People Mental Health and Learning Disability service users, including community and inpatient locations. This will commence for quarter 1 of 2016/17 and will be shared with locality Learning from Experience groups to then inform the aggregated Learning from Experience report to Quality Committee and Board.	Safe Services Department has provided a report on all deaths reported on its clinical management and reporting systems. This was presented at a mortality meeting with the Director of Nursing, Therapies & Patient Partnership, Associate Director of Safe Services, Head of Clinical Governance, Head of Safeguarding, and Incidents Team Manager. This identified the further action identified in 2b. **Transfer action to quality improvement programme for learning, candour and accountability.**
19	The spreadsheet arrangement currently in place in TQ21 is insufficient to monitor deaths at corporate level as part of the whole Learning Disability service provision. TQ21 service users	CWP provides reports to monitor deaths for the weekly Meeting of Harm. All information is recorded onto Datix.	No further action currently.	As 2b.

	should be incorporated into Trust administration systems in a way which ensures their deaths are captured for reporting and investigation purposes.			

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Safer Staffing Six Monthly Review
Agenda ref. no:	16_17_116a
Report to (meeting):	Board of Director
Action required:	Discussion and Approval
Date of meeting:	25/01/2017
Presented by:	Gary Flockhart, Deputy Director of Nursing

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	No
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	No
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
N/A	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
N/A	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*
This report has been produced to provide Board members with details of the findings of the Safer Staffing six month review, covering May 2016 to October 2016, in line with NHS England and the National Quality Board [NQB] requirements. The information in this report is based on meetings with staff members, safer staffing group meetings, desk top review, and analysis of data.

Background – *contextual and background information pertinent to the situation/ purpose of the report*

In January 2014, the Operational Board and Board of Directors received and approved a paper setting out the Trust's current position in relation to ward staffing, vacancies, skill mix and areas for improvement following a comprehensive review led, on behalf of the Board, by the Associate Director of Nursing & Therapies (MH). Since the initial review there have been five, six monthly follow up reviews (including this one). Additionally, monthly reports have been provided to the Board of Directors from June 2014 onwards. In order to comply with NHS England and NQB requirements these reports and the Trust's performance are also published on CWP and NHS Choices websites.

Assessment – *analysis and considerations of options and risks*

The report details findings from actions agreed at the Operational and Trust Boards in July 2016 in relation to:

- Themes arising from ward reviews
- Ward sample triangulation
- Impact on breaks
- Hurst National Pilot and National Benchmarking
- Follow up actions relating to deep dive and e-roster update
- Recruitment and retention in relation to original recommendations
- Widening the consideration of MDT in relation to Safer Staffing (OT update)
- Context of Safer Staffing within community MH and LD teams
- Safer Staffing Community Physical Health update

As per previous six monthly reviews, the overall view of the clinical teams was that rather than issues with ward establishments, they reported ongoing issues in relation to requirements to backfill vacancies and absence. The exceptions to this are Oaktrees and Adelphi which require additional consideration.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*

The Board of Directors is recommended to **approve** the recommendations and approach to future work streams as set out in appendix 1: "Six Monthly Safer Staffing Review"

Who/ which group has approved this report for receipt at the above meeting?	Avril Devaney, Director of Nursing
Contributing authors:	Gary Flockhart and Anne Casey

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Operational Board	18 January 2017

Appendices provided for reference and to give supporting/ contextual information:

Appendix no.	Appendix title
1 2	Safer Staffing Six Monthly Review Ward fill rates May 2016 to October 2016

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October 2016 Six Monthly Ward Staffing Review

1 Introduction

This report has been produced to provide Board members with details of the findings of the Safer Staffing six month review, covering May 2016 to October 2016, in line with NHS England and the National Quality Board [NQB] requirements. The information in this report is based on meetings with staff members, safer staffing group meetings, desk top review, and analysis of data.

The report summarises key actions completed to date and further action required based on the findings of the review.

1.1 Background to the Ward Nurse staffing review

- Since the initial review presented to Board in January 2014 there have been five, six monthly follow up reviews (including this one). Additionally, monthly reports have been provided to the Board of Directors from June 2014 onwards. In order to comply with NHS England and NQB requirements these reports and the Trust's performance are also published on CWP and NHS Choices websites. The Director of Nursing continues to have oversight of ward staffing levels and reports directly to the Board of Directors in line with the NQB requirements.

- The October 2016 review was carried out by the Associate Director of Nursing and Therapies (MH and LD) with support from the Head of Performance and Information, Nurse Consultant in Adult Acute Care (MH) and Senior Occupational Therapists. CWP adopted the approach from the initial staffing review which recommended the continuous improvement of workforce practices alongside considering safe staffing levels in relation to nursing, the wider Multi-Disciplinary Team (MDT) and other professions.

- The reviewers met with representatives from each ward including General Managers, Clinical Service Managers, Ward Managers, Modern Matrons, and Allied Health Professionals in order to discuss issues currently impacting on ward staffing on a shift by shift basis and progress made since the last review. The areas discussed covered the range of factors impacting on nursing care challenges and the delivery of high quality care. The ward representatives were challenged on areas of practice and assumptions in order to support the resulting conclusions and recommendations.

- The review team undertook analysis of the information available and have made recommendations to the Board within this report.

- The review team have continued to engage with the MH safer staffing national programme being led by NHS improvement.

2 Report findings

The report consists of a number of reviews and analysis encompassing a comprehensive programme of work in relation to safer staffing progressed since May 2016 and reviewed in November 2016, comprising the following areas:

2.1 Themes arising from ward reviews
2.2 Ward sample triangulation
2.3 Impact on breaks
2.4 Hurst National Pilot and National Benchmarking
2.5 Follow up actions relating to deep dive and e-roster update
2.6 Recruitment and retention in relation to original recommendations
2.7 Widening the consideration of MDT in relation to Safer Staffing (OT update)
2.8 Context of Safer Staffing within community MH and LD teams
2.9 Safer Staffing Community Physical Health update

3 Conclusion and Recommendations

2.1 Themes arising from ward reviews

Methodology
The six-monthly ward staffing review was undertaken in October 2016. The review included both qualitative and quantitative data and methodology, following the Telford Model which uses a consultative approach based on professional judgement. To ensure the robustness of this approach, and to reduce bias, quantitative data from a number of sources was used to aid triangulation (section 2.2).

Key findings
As per previous reviews, the clinical teams continue to demonstrate an ongoing commitment to delivering high quality care with the Trust values of the 6Cs being embedded into practice. There was a noticeable positive impact on morale when compared to the initial review 3 years ago and ward teams noted the impact of the investment in nurse staffing numbers agreed by the board in January 2014. Whilst morale was reported to be high a number of themes for consideration arose from the interviews with the ward clinical teams, as detailed below.

The themes raised below were largely reported as a general overview of any issues or challenges as raised by the clinical and managerial teams. Following on from the previous six monthly report, it was identified that there needed to be an increased focus on available data to aid triangulation. The first iteration of this approach is outlined in section 2.2.

2.1.1 Acute wards [Bollin, Beech and Lakefield]

Findings
• The review found that the overall view of the management team is that ward establishments continue to be fit for purpose. The management teams are keen to have a flexible approach to manage change to meet clinical need. • Similar themes were raised as per the previous six monthly review, in that it was reported that safer staffing does not appear to be in relation to ward establishments but rather the impact of sickness, maternity leave, secondments and restrictions in practice during HR investigations and the requirement to backfill or cover these posts. It was also reported that high observation levels can have an impact on staffing fill rates (i.e. where staff are required in addition to baseline establishment). The Ward Managers, Clinical Service Managers and General Managers continue to report that the role of the Resource Manager is essential to support the management of these issues and this ensures the clinical visibility of the Ward Managers. • Where staffing establishments are fully met, this has led to more opportunities for the Ward Manager and Clinical Leads to spend time with staff for education and support. • There are occasions where it has been challenging to release staff to attend mandatory training.
Action
• The safer staffing group now considers “truth on a page” (staffing, vacancy attendance figures) on a monthly basis and clinical services are engaged with Human Resources and workforce development.

2.1.2 Open age acute wards [Adelphi, Juniper and Brackendale]

Findings
• The review found that, similar to the acute and dementia wards, the most significant factors in relation to safer staffing do not appear to be in relation to ward establishments but rather the impact of sickness, maternity leave, secondments and restrictions in practice and the requirement to backfill or cover these posts. • Following the previous staffing review, Juniper has seen a reduction in vacancies, improved management of sickness and a reduction in sickness rates and has also received a positive CQC visit and report.
Action
• Board are asked to note that Adelphi has consistently higher bank use to support increased observations; inclusive of physical health needs and environmental challenges and should be supported to use additional bank shifts to maintain safer staffing levels where required.

2.1.3 Organic wards [Croft, Cherry and Meadowbank]

Findings

- The review found that again the overall view from the management team was that ward establishments are good and the initial staffing review has had a positive effect for patients, carers and staff.
- Cherry ward reported good levels of staff work satisfaction with positive morale and staff engagement. Since the last 6 month review there has been a reduction in sickness.
- Since the previous review, the Meadowbank staff team feels they are working more cohesively. Meadowbank is currently under budget and are managing bank staff well. The team reported that the new managing absence policy is having a positive effect.
- Croft ward reported challenges to recruitment and retention of staff.

Action

- To continue to monitor safer staffing fill rates, take mitigating actions to backfill and escalate concerns as appropriate.

2.1.4 CAMHS wards [Coral and Indigo]

Findings

- This is the first review since CAMHS relocated to Ancora House, however, the review found that both CAMHS wards are satisfied with their current establishments. The main factors impacting on staffing are high levels of sickness and maternity leave. Absence is being managed as policy with various levels of management stages in place.
- Staff have been required to move to different areas but these moves have been predominantly between Coral and Indigo within Ancora ensuring consistent input of specialist nursing knowledge. When staff are moved there has subsequently then been the need for other disciplines in the MDT to be more involved in hands on daily care.

Action

- Review the establishment once the unit is at full occupancy to ensure the management team remain satisfied.
- Since the review has been undertaken, CAMHS have successfully recruited a nurse consultant.

2.1.5 Eating Disorder ward [Oaktrees]

Findings

- The team reported challenges in relation to the ward environment and the level of physical health care required. There are ongoing demands on staff due to the MARSIPAN pathway.
- In the past 12 months the team have reported an improvement in effective team working. However, long term sickness in relation to nursing and therapies staff has been an issue and continues to be managed as per the policy.
- Following a budget review, some reconfiguration has allowed recruitment of two registered nurses.
- The ward is currently engaged in a national pilot in relation to developing a profile for inpatient eating disorder services using the Hurst Safer Staffing Tool.

Action

- Clinical and Operational services to review the level of funding available for the

MARSIPAN pathway in line with any increase in demand. • Support the ward team with the Hurst national pilot.

2.1.6 Rehabilitation and Recovery wards [CARS, Limewalk House and Rosewood]

Findings
• The teams reported establishments are good across the three wards. The significant impacts for CARS ward being sickness, vacancies, secondments and difficulty in recruitment. Rosewood is managing long term sickness. Note – since the review CARS ward has been decommissioned.
Action
• East locality continue to use wider methods of recruitment including exploring ward based O.T.s as part of the staffing establishment.

2.1.7 Saddlebridge and Alderley

Findings
• Saddlebridge reported some clinical challenges during the review period in relation to maintaining safer staffing in relation to clinical activity (transfer to acute hospital and increased observations). Which has meant the clinical leads have been unable to take their management days in order the cover the ward. • Since the last review, however, Saddlebridge has been able to cut back on bank usage, thus reducing overspend, and reported no issues with the establishment. However, the ward reported a high number of registered nurse vacancies during the period which they are working to resolve. • Alderley reported no issues with the establishment.
Action
• To continue to monitor safer staffing fill rates, take mitigating actions to backfill and escalate concerns as appropriate.

2.1.8 PICU Wards [Willow and Brooklands]

Findings
• Both teams reported no issues with the establishment and sickness has improved on Willow. Both wards have successfully recruited consultant psychiatrists.
Action
• To continue to monitor safer staffing fill rates, take mitigating actions to backfill and escalate concerns as appropriate.

Note: there is a continued commitment for operational services to continue to work with clinical support services to ensure that processes support and enable (and not duplicate)

wards in areas including Human Resources, Finance and recruitment and retention which is an integral component of the safer staffing group.

Proposed Service Redesign Central and East
As part of the 5 year forward view (FYFV) there will be a redesign of mental health services in Central and East. This process has caused some anxiety within the inpatient teams and there is an ongoing risk that staff will seek employment elsewhere, there may be challenges in recruitment which may have an adverse effect on sustaining safe staffing levels. This has been raised as a risk within operational services and is being monitored closely should this become unsustainable.

Eastway and Greenways
There is a Trust-wide review currently being undertaken in line with national guidance related to services for people with learning disabilities and therefore no change to the current staffing levels on these wards is recommended at this time.

2.2 Ward sample triangulation

The NQB released additional guidance in relation to safer staffing in July 2016 which re-emphasised the need to focus on "more than just numbers" and to consider wider indicators in relation to safer staffing, across three domains:

- Expectation 1: Right Staff
- Expectation 2: Right Skills
- Expectation 3: Right Place and time

To further build this approach (detailed in previous reports) a sample of wards were selected for more detailed triangulation in relation to these areas.

Note:

- The information as presented is intended to provide a wider context in relation to ward activity as opposed to suggest any direct correlation between safer staffing and other indicators.

- Incident numbers represent the total number of incidents reported regardless of grade or type.

Summary Data: [Wards were selected for triangulation based on 3 or more occasions over a 6 months period whereby registered nurse fill rate fell below 95%. Fill rates in tables are combined RN and CSW rates]

NQB Requirement	Metric	Score range	Average	Median
Expectation 1: Right Staff	Ward Staffing	Lowest: 86.5% Highest: 101.4%	95.25%	96.05%
Expectation 1: Right Staff	Absence	Lowest: 0.06% Highest: 15.77%	7%	6.34%
Expectation 2: Right Skills	Essential Learning	Lowest: 80% Highest: 92%	87%	87%
Expectation 2: Right Skills	Supervision	Lowest: 10% Highest: 100%	76%	78%
Expectation 3: Right Place and time	Incidents	Lowest: 9 Highest: 51	25.19	26

Adelphi:

NQB Requirement	Metric	May	June	July	Aug	Sept	Oct
Expectation 1: Right Staff	Ward Staffing	95.50%	95.90%	96.80%	98.40%	96.20%	96.20%
Expectation 1: Right Staff	Absence	0.49%	3.09%	1.31%	0.42%	8.93%	5.33%
Expectation 2: Right Skills	Essential Learning	89%	89%	92%	88%	83%	88%
Expectation 2: Right Skills	Supervision	69%	50%	70%	58%	57%	72%
Expectation 3: Right Place and time	Incidents	38	31	32	27	34	27

Beech:

NQB Requirement	Metric	May	June	July	Aug	Sept	Oct
Expectation 1: Right Staff	Ward Staffing	97.7%	98.4%	101.4%	96.2%	94.8%	96.5%
Expectation 1: Right Staff	Absence	0.06%	3.44%	0.73%	0.97%	0.72%	7.44%
Expectation 2: Right Skills	Essential Learning	87%	86%	86%	81%	80%	86%
Expectation 2: Right Skills	Supervision	96%	81%	83%	91%	75%	89%
Expectation 3: Right Place and time	Incidents	26	31	28	29	26	28

Brooklands:

NQB Requirement	Metric	May	June	July	Aug	Sept	Oct
Expectation 1: Right Staff	Ward Staffing	96.8%	94.2%	91.6%	93.4%	94.9%	89.5%
Expectation 1: Right Staff	Absence	3.12%	6.00%	4.76%	4.60%	5.00%	7.69%
Expectation 2: Right Skills	Essential Learning	89%	85%	86%	87%	87%	88%

Expectation 2: Right Skills	Supervision	85%	78%	69%	93%	88%	61%
Expectation 3: Right Place and time	Incidents	23	25	26	21	23	26

Croft:

NQB Requirement	Metric	May	June	July	Aug	Sept	Oct
Expectation 1: Right Staff	Ward Staffing	87.1%	86.5%	89.7%	91.5%	92.2%	94.4%
Expectation 1: Right Staff	Absence	14.41%	11.36%	6.65%	11.06%	10.95%	5.09%
Expectation 2: Right Skills	Essential Learning	88%	86%	87%	89%	89%	87%
Expectation 2: Right Skills	Supervision	61%	62%	70%	10%	41%	58%
Expectation 3: Right Place and time	Incidents	51	28	27	22	30	30

Meadowbank:

NQB Requirement	Metric	May	June	July	Aug	Sept	Oct
Expectation 1: Right Staff	Ward Staffing	99.8%	91.9%	92.1%	95.7%	98.5%	97.9%
Expectation 1: Right Staff	Absence	2.82%	4.44%	8.69%	6.14%	10.53%	8.36%
Expectation 2: Right Skills	Essential Learning	85%	87%	86%	90%	91%	92%
Expectation 2: Right Skills	Supervision	88%	91%	98%	87%	94%	94%
Expectation 3: Right Place and time	Incidents	13	20	10	23	9	17

Rosewood:

NQB Requirement	Metric	May	June	July	Aug	Sept	Oct
Expectation 1: Right Staff	Ward Staffing	94.3%	93.8%	94.3%	97.1%	97.2%	97.6%
Expectation 1: Right Staff	Absence	5.36%	15.77%	14.95%	12.56%	15.44%	13.85%
Expectation 2: Right Skills	Essential Learning	82%	82%	83%	86%	80%	83%
Expectation 2: Right Skills	Supervision	76%	77%	70%	68%	73%	58%
Expectation 3: Right Place and time	Incidents	12	11	34	49	50	23

Impact of Resource Managers

During this review it was reported that the Resource Manager role is highly valued within ward teams across the Trust. Areas of positive impact reported in relation to the role include increase in Ward Managers' visibility, patient and carer engagement and clinical leadership, significant improvements in processes in relation to management of staffing and HR issues. Ward Managers reported increased satisfaction with their role feeling Resource Managers were contributing to this. An impact assessment has been undertaken for consideration by the Director of Nursing.

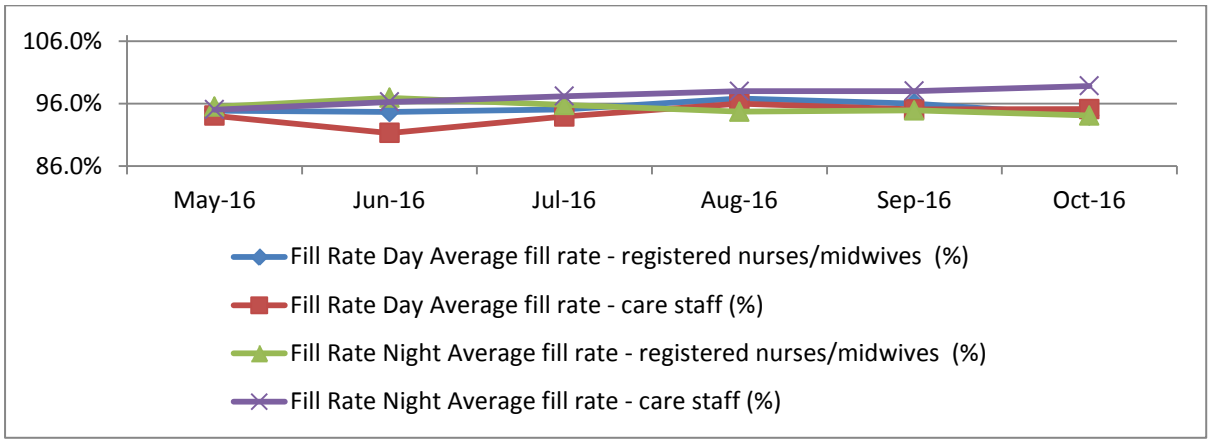
2.3 Impact on Breaks (November 2016 - onwards)

To further enhance analysis of impact, the Resource Managers will report on staff activities cancelled due to staffing levels/clinical activity. This was raised via the health roster project group from November 2016 and will be reported into future safer staffing groups to examine any trends or outliers, this will also inform clinical presence visits by the Associate Director of Nursing and Therapies (MH & LD).

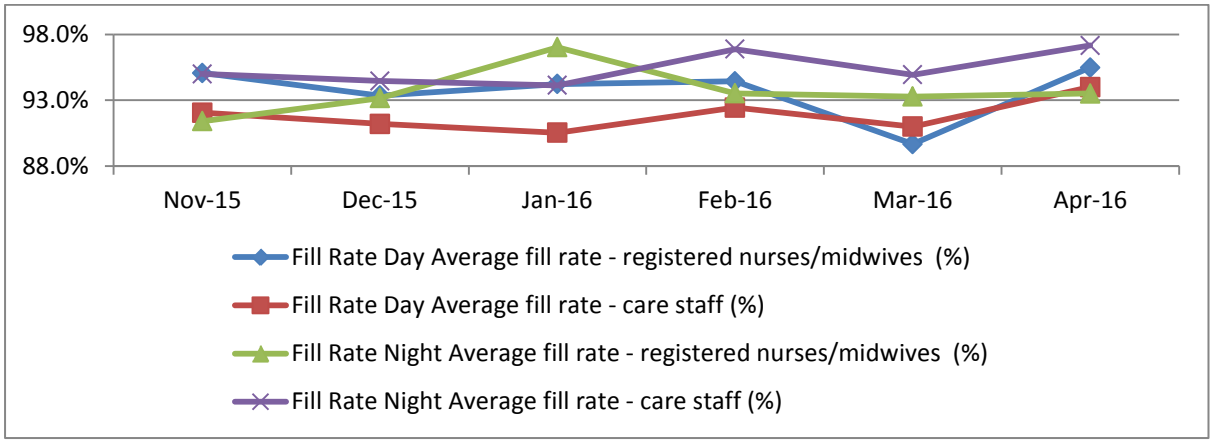
Quality and Safety

This section identifies how wards are maintaining safe staffing levels, the potential impacts and the actions being undertaken currently, alongside future recommended actions, to minimise potential negative impacts.

The CWP reports submitted to UNIFY from May 2016 – October 2016 demonstrate that ward staffing actuals have been over 90% of planned staffing as shown in the graph below:



This is broadly comparable with the previous 6 months reporting period [November 2015 to April 2016]



Interventions to maintain safe staffing levels

The action taken by the Board in agreeing the safe staffing levels recommendations from the initial review alongside the subsequent work of the programme board and ward teams has had a significant impact in ensuring that CWP wards are safely staffed. On an on-going

basis there are a further four key interventions that contribute to maintaining safe staffing levels. Firstly, effective rostering (see section 2.5), secondly the use of temporary staff to backfill shortfalls, thirdly, actions taken by ward staff to mitigate against the potential impact of unfilled shifts, and the involvement of the Multidisciplinary Team, not just nursing staff.

Temporary staffing - bank and agency use

From May - October 2016 the following details temporary staffing activity:

Locality	Total Hours Requested	Total Hours Filled	Bank/Agency Fill Rate (%)	% of Total Planned Hours on Ward covered by Bank/Agency May-Oct 2016	WTE filled by Bank	WTE filled by Agency	Total WTE filled
East	48051	37916	79	19	38.90	0	38.90
West	40050	27481	69	16	27.90	0.3	27.90
Wirral	24730	19782	80	15	20.30	0	20.30
Trustwide	**112830**	**85179**	75	**17**	87.10	**0.3**	**87.10**

Bank use has fallen from 97 WTE October 2015 – March 2016 to 87 WTE in this current six monthly review (a PICU ward moved from West to Wirral figures from July 2016). This is compared to 118 WTE 12 months prior to the original staffing review. Agency use has been 0.3 WTE during this time and the agency bookings were within NHS Improvement rules. On average over the six months, based on booking reasons used by the wards, approximately 17% of requests were due to vacancy, 16% due to sickness, 24% due to other absence reasons and 42% due to increased workload reasons. These figures would support information received from the ward teams that these areas have an impact on sustaining safer staffing as opposed to actual establishments.

Actions taken by ward staff

Each month Clinical Service Managers report on the actions taken to maintain safe staffing levels on wards. The same themes arise each month and include:

- Nursing staff working additional hours – either by not taking a break or working beyond the end of their shift.
- Nursing staff cross covering wards to maintain safe staffing.
- RN shifts being backfilled by CSWs when RN cover cannot be sourced.
- Ward Managers working in the numbers rather than supernumerary status.
- Multi-disciplinary teams supporting nursing staff in delivering planned care.
- Patient care being prioritised over non-direct care activities such as mandatory training, supervision and appraisal.
- Patient activities being cancelled or shortened due to nurse staffing levels.

The above themes have previously been raised at Operational Board and are consistent with previous reports.

Managing challenges and risks
Whilst wards at times struggle to achieve maximum fill rates, to support the wards to maintain staff staffing the following are in place to identify issues relating to safe staffing levels or risks relating to staffing and to enable escalation and resolution:

- Locality data packs.
- Exception reporting on a monthly basis to Operational Board via key lines of enquiry for localities [KLOE'S].
- Ward escalation process for safe staffing (currently being reviewed as part of a national consultation).
- Truth on a Page.

Use of lean methodology – inpatient service improvement forum
Following the disestablishment of the Ward Manager Task and Finish Group, an Inpatient Service Improvement Forum has been established. The forum now includes wider representation from inpatient services and closer links with corporate services. The purpose of the forum is to promote an ethos of continuous improvement, part of which will look to address a reduction in unwarranted variation with a focus on lean methodology.

2.4 Hurst National Pilot and National Benchmarking

The National Quality Board requires all NHS Trusts to use evidence based tools to inform safe staffing capacity and capability to ensure the Right Staff, Right Skills in the Right Place and Time.

The trust is currently in the process of implementing the Hurst Tool (led by the Nurse Consultant in acute care). A consistent approach was used to validate quality findings from each ward supported by Lead Occupational Therapists from each area. To proceed to the next stage of the audit a result of 70% success from each ward was required.

Initial stage of the Service Quality Audit were completed in December 2016 and externally validated by the national team (Hurst safer staffing). The quality audit covered five domains (assessing, planning, implementing, evaluating and ward centred). The overall scores are detailed below:-

- Oaktrees (EDS): overall 94%
- Beech (acute): overall 94%
- Saddlebridge (low secure): overall 97%
- Brooklands (PICU): overall 94%
- Lakefield (acute): overall 94%
- Cherry (older people): overall 97%

Note: the national team reported that these scores were in the top 10% of wards on the database.

All wards qualified for the national pilot (based on quality audit scores). The next stage requires Ward Managers to collate ward staffing data, establishments and to rate the dependency presentation of all the patients on their ward and to review this consistently over a 14 day period. This will commence first week in January 2017 all Ward Managers will be supported by the Nurse Consultant to complete this audit.

The national database for inpatient wards, using Hurst's safer staffing model, does not contain ward profiles for inpatient eating disorder services. As part of the national pilot, Oaktrees will be participating in the full quality audit, dependency profiling and staff activity data collection. It is envisaged that this will support the action previously identified that Oaktrees staffing levels should be subject to review.

2.5 Follow up actions relating to deep dive and E-Roster Update

The previous 'deep dive' analysis of e-rostering and associated links with bank usage and sickness absence suggested that there was scope for improvement in rostering practices. Support People Services worked with localities to further investigate the themes emerging from the deep dive to examine effective and efficient use of the roster and take remedial actions where necessary.

The recommendations from the ward deep dive exercises were to reinvigorate rostering practice via improved software, agreed standardised operating procedures and a revised overarching policy. In June 2016, a successful business case was developed for investment in the e-rostering product (Healthroster). As part of the implementation, focus groups for stakeholders have been held and the project group has been established to agree the revised processes and policy in order to support the new product and maximise rostering effectiveness in the trust.

The first meeting of the project group was held on 31st October 2016. The key areas of focus for the group are to test software, review, agree and update processes and procedures and deliver an updated draft policy which clearly defines these processes and roles and responsibilities which will deliver effective rostering within the trust. Resource Managers are the primary leads for services and ensure their Ward Managers are updated with progress. The group also has staff side representation included in the terms of reference. The go live date for the new software is 19th January 2017.

Risk Identification from Health Roster Group
One of the key areas to take forward with the new system is how to further improve predictable and non-predictable risk to safer staffing. This will be progressed and reported within the safer staffing group (as well as the health roster project group).

2.6 Recruitment and retention in relation to original recommendations

It was recognised in previous reports that it was difficult to fully realise the benefits of increased staffing establishments when wards still had significant vacancies. In particular due to the number of newly qualified staff requiring preceptorship and the need to balance this against the number of experienced staff.

The table below indicates the establishments, vacancies and numbers in recruitment as at October 2016. The average recruitment time from vacancy created to contract letter was 54.3 days in October which has reduced to 60 days since the introduction of new recruitment software, Trac, in June 2015. Also during this time the Resourcing team have developed an attraction strategy and regularly attend careers and jobs fairs while developing stronger links with the PEF team and universities. On average over the reporting period vacancies as a proportion of establishment have been 5.87% for registered nurses and 4.35% for clinical support workers. In September this reduced to 2.57% for registered nurses and CWP was over established for clinical support workers by 0.87%.

Trust Wards	Current WTE [budgeted establishment]	Current WTE [Staff in post]	Staffing differential	Current WTE in recruitment (from out to advert to start date booked)
Registered Nurses	304.84	287.17	17.67	23.61
Clinical Support Workers	309.22	305.16	4.06	9

2.7 Widening the consideration of MDT in relation to Safer Staffing

Following on from the original ward staffing review it was recommended that a similar review be undertaken in relation to the Occupational Therapy (O.T) inpatient services. This aligns with current national acknowledgment that nurse staffing does not support wards independently and that the Multidisciplinary Team (MDT) plays a significant role in ensuring that wards are safely staffed. A recommendation from the previous safer staffing report was to present an overview of O.T provision across the Trust within inpatient acute mental health services, to contribute to the wider inpatient Safer Staffing review.

Summary of findings from In-patient O.T review, the following recommendations were approved at November People Organisational Development Sub Committee in relation to:

- **Safer staffing** - Workforce planning and service developments within occupational therapy acute care services should be considered within the context of the Safer Staffing agenda, to ensure a sustainable and quality service. Occupational Therapists will be included in the core inpatient Safer Staffing reviews in the future.

CWP is currently piloting a revised edition of the Hurst Tool as part of the Safer Staffing agenda, and occupational therapists are involved in this initiative.

- **Quality and patient experience -** Occupational Therapy services should employ bench marking and audit tools, and reference and adopt current evidence based practice, to ensure they maintain a safe, effective and efficient service. The Lead Occupational Therapists in each locality should continue to consult and share best practice across their services and develop a future plan for audit and evaluation.

- **Leadership -** Skilled professional leadership is required to continue ensuring effective and quality services are delivered in acute care, and to develop future clinical leaders. Occupational Therapists need to strengthen professional and clinical networks locally and nationally. Current professional networking links encompass local, trust wide and regional Allied Health Professional and O.T groups.

2.8 Context of Safer Staffing within community MH and LD teams

Transforming Care Agenda

There is a trust wide project aimed at transforming services for people of all ages with a learning disability and / or autism who display behaviour that challenges, including those with a mental health condition, in line with *Building the Right Support* to implement the national service model by March 2019 by reducing inpatient beds and realigning funding to community-based support. Part of the review will include ensuring effective staffing.

As part of the five year forward view a review of the model of community mental health care is currently being considered by a separate project group to support the development of proposals.

2.9 Safer Staffing Community Physical Health update

An early warning system to support appropriate escalation where demand for resource is beyond the capacity available, has been developed supported by safe services, this tool is being piloted currently and changes to escalation process are being made as part of a PDSA cycle. The service has completed its deep dive into the integrated teams, which has provided a historical and current contextual overview of capacity and demand, which has highlighted that further work is required in between information support and the service to accurately report on activity levels. Feedback sessions with the staff have been undertaken and an action plan to address the recommendations is in development by the service. Several models nationally are emerging which the group will consider to develop a robust framework which provides assurance that these elements are reflected in staffing establishment numbers, and that levels of safe staffing are monitored in line with the in-patient services reports. The Trust is working with West Cheshire Clinical Commissioning Group (WCCCG) to update the service model for community physical health (District Nursing / integrated teams) which will provide the stability of ensuring that work undertaken by the service is commissioned appropriately. This will provide a foundation from which work can

be undertaken to predict demand and highlight what resource is required to meet the demand. Nationally several methods to understanding safe caseload management are emerging, CWP is working with other community providers across Cheshire and Wirral to consider if a health-economy wide approach can be adopted to facilitate benchmarking.

3 Conclusion and Recommendations

The review team would like to acknowledge the commitment within clinical services to ensure the ongoing provision of high quality care and in their work supporting the safer staffing six monthly review. The board are respectfully requested to consider and approve the following recommendations:

1. To note the content of the report and the key recommendation that ward establishments should be sustained at current levels to maintain safer staffing.

2. To continue to progress relevant workstreams as detailed within the Safer Staffing Working Group in particular in relation to:

    - The next six monthly safer staffing review.
    - Linking in with national work programmes in relation to safer staffing.

3. There should be recognition and acceptance that due to environmental constraints and high levels of observations required to meet physical and mental health needs, Adelphi requires to use varying degrees of bank use to ensure ongoing safer staffing requirements.

4. Resource Managers to collate and forward staff activities cancelled on a monthly basis for consideration to the safer staffing group.

5. Revisit ward escalation process for safe staffing (currently being reviewed as part of a national consultation).

6. The next six monthly review period will revisit and detail variance across structures and band profiles to support trustwide benchmarking.

7. Undertake activity follows in relation to occupational therapy, specifically looking at support in relation to adult acute wards and maintaining safer staffing.

8. Detail in relation to the triangulation of evidence will be reported to operational board on an ongoing basis.

Appendix 2

Month and Year of Data	Locality	Ward	Day				Night				Fill Rate			
			Registered midmives/nurses		Care Staff		Registered midmives/nurses		Care Staff		Day		Night	
			Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)
May-16	East	Adelphi	1343	1287	1371.5	1271	713	702	1403.5	1332.5	95.8%	92.7%	98.5%	94.9%
Jun-16	East	Adelphi	1311	1239	1225	1202	767	767	1163	1057	94.5%	98.1%	100.0%	90.9%
Jul-16	East	Adelphi	1316	1251	1212	1189	747.5	736	1035	989	95.1%	98.1%	98.5%	95.6%
Aug-16	East	Adelphi	1413	1329	1025	1046.25	713	724.5	1081	1035	94.1%	102.1%	101.6%	95.7%
Sep-16	East	Adelphi	1338	1261	1054.5	1036.5	701.5	701.5	1058	977.5	94.2%	98.3%	100.0%	92.4%
Oct-16	East	Adelphi	1287	1162	1017.5	1022.5	713	678.5	1088.5	1077	90.3%	100.5%	95.2%	98.9%
May-16	East	Alderley	874.5	858.5	1328	1316	701.5	639	736	764	98.2%	99.1%	91.1%	103.8%
Jun-16	East	Alderley	879	818.5	1378.5	1387	679	686	717	694	93.1%	100.6%	101.0%	96.8%
Jul-16	East	Alderley	868	790	1419	1416	713	677	713	747.5	91.0%	99.8%	95.0%	104.8%
Aug-16	East	Alderley	906.5	903	1445	1365	713	688.5	713	786	99.6%	94.5%	96.6%	110.2%
Sep-16	East	Alderley	893.5	941	1425.5	1322	678.5	637	769	748	105.3%	92.7%	93.9%	97.3%
Oct-16	East	Alderley	1015	923.5	1407	1355	713	655.5	759	797.5	91.0%	96.3%	91.9%	105.1%
May-16	East	Bollin	1369	1349	1335	1259.5	865.5	846.5	1235	1154.5	98.5%	94.3%	97.8%	93.5%
Jun-16	East	Bollin	1119	1101	1397	1457	744	771	1261	1264	98.4%	104.3%	103.6%	100.2%
Jul-16	East	Bollin	1110.5	1076	1446.5	1423.5	769	757.5	1339	1339	96.9%	98.4%	98.5%	100.0%
Aug-16	East	Bollin	1360	1310	1366.5	1297.5	777	719.5	1247	1235	96.3%	95.0%	92.6%	99.0%
Sep-16	East	Bollin	1217	1204	1312	1296	805	701.5	1154.5	947.5	98.9%	98.8%	87.1%	82.1%
Oct-16	East	Bollin	1340	1221	1299.5	1266.5	747.5	747.5	1357	1276.5	91.1%	97.5%	100.0%	94.1%
May-16	East	CARS	937.5	890.5	1177	1090.5	713	685	713	573.5	95.0%	92.7%	96.1%	80.4%
Jun-16	East	CARS	876	844	1168	1127	702	686	690	551	96.3%	96.5%	97.7%	79.9%
Jul-16	East	CARS	894	855	1233	1180.5	713	679	713	621	95.6%	95.7%	95.2%	87.1%
Aug-16	East	CARS	862	904.5	1255.5	1146.5	701.5	683	713	636.45	104.9%	91.3%	97.4%	89.3%
Sep-16	East	CARS	873	814.5	1168	1103.5	678.5	632.5	644	563	93.3%	94.5%	93.2%	87.4%
Oct-16	East	CARS	879	821	1130.5	1071.5	713	585.5	448.5	513.5	93.4%	94.8%	82.1%	114.5%
May-16	East	Croft	1365.25	1375.05	1577.75	1248	769.5	649	1737	1466.5	100.7%	79.1%	84.3%	84.4%
Jun-16	East	Croft	1057	977.35	1736.5	1366.5	750.5	697	1480.5	1216	92.5%	78.7%	92.9%	82.1%
Jul-16	East	Croft	1060	1018.25	1700	1385.75	736	722	1450	1203.75	96.1%	81.5%	98.1%	83.0%
Aug-16	East	Croft	1103.75	1027.4	1567.023	1369.5	759	729.5	1459	1304	93.1%	87.4%	96.1%	89.4%
Sep-16	East	Croft	959.5	919.45	1446.5	1295.7	690	637.25	1460.5	1327	95.8%	89.6%	92.4%	90.9%
Oct-16	East	Croft	1100.5	1022.5	1573	1522.5	713	621	1437.5	1446.5	92.9%	96.8%	87.1%	100.6%
May-16	East	Greenways	1298	1275	2247.5	2029	713	552	1115.5	1179.5	98.2%	90.3%	77.4%	105.7%
Jun-16	East	Greenways	1267.5	1205.5	2291	1885	690	560	1380	1441.5	95.1%	82.3%	81.2%	104.5%
Jul-16	East	Greenways	1269	1260	2433.5	2159	713	529	1426	1511.5	99.3%	88.7%	74.2%	106.0%
Aug-16	East	Greenways	1241.5	1230.5	2365	2082.5	713	609.5	1391.5	1441.5	99.1%	88.1%	85.5%	103.6%
Sep-16	East	Greenways	1267.5	1209.5	2188	1966.5	690	552	1357	1460.5	95.4%	89.9%	80.0%	107.6%
Oct-16	East	Greenways	1268.5	1045.5	2248.5	2016.5	713	517.5	1414.5	1529.5	82.4%	89.7%	72.6%	108.1%
May-16	East	LimeWalk	1151	1098.5	1044.5	975.5	726	659.5	667	597	95.4%	93.4%	90.8%	89.5%
Jun-16	East	LimeWalk	958.3	913.3	1168	1083	685	652	690	651	95.3%	92.7%	95.2%	94.3%
Jul-16	East	LimeWalk	1079	1067.5	1144	1051	717.5	683	759	695.5	98.9%	91.9%	95.2%	91.6%
Aug-16	East	LimeWall	1107.5	1068.5	1121	1117	713	683	713	720	96.5%	99.6%	95.8%	101.0%
Sep-16	East	LimeWalk	1203.25	1099.75	966	949	690	678.5	701.5	683	91.4%	98.2%	98.3%	97.4%
Oct-16	East	LimeWalk	1195.5	1146	962.5	839	736	632.5	713	654	95.9%	87.2%	85.9%	91.7%
May-16	East	Saddlebridge	813	778.5	1601.5	1608	742	730.5	975.5	945.5	95.8%	100.4%	98.5%	96.9%
Jun-16	East	Saddlebridge	937	925	1372	1378	678	678	857	857	98.7%	100.4%	100.0%	100.0%
Jul-16	East	Saddlebridge	912.5	895.5	1395.5	1377	690	632.5	746.5	780.5	98.1%	98.7%	91.7%	104.6%
Aug-16	East	Saddlebridge	901	866.5	1398.5	1370.5	667	667	759	759	96.2%	98.0%	100.0%	100.0%
Sep-16	East	Saddlebridge	817.5	806	1270.5	1269.5	667	678.5	713	713	98.6%	99.9%	101.7%	100.0%
Oct-16	East	Saddlebridge	934	911	1442.5	1415.5	644	621	793.5	828	97.5%	98.1%	96.4%	104.3%
May-16	West	Beech	1472.5	1398	1038.5	999.5	721.5	720.5	874	872	94.9%	96.2%	99.9%	99.8%
Jun-16	West	Beech	1278	1187	1144.5	1180.5	632.5	632.5	713	695	92.9%	103.1%	100.0%	97.5%
Jul-16	West	Beech	1173.15	1178	1127	1131	655.5	655.5	690	724.5	100.4%	100.4%	100.0%	105.0%
Aug-16	West	Beech	1225	1186	1081	1062.5	689	664	724.5	676.5	96.8%	98.3%	96.4%	93.4%
Sep-16	West	Beech	1322	1290	1069.5	996	678.5	621	793.5	770.5	97.6%	93.1%	91.5%	97.1%
Oct-16	West	Beech	1421.5	1420	1069.5	953	690	690	766	742	99.9%	89.1%	100.0%	96.9%
May-16	West	Cherry	1265.5	1133.5	1046.5	886	736	701.5	954.5	654	89.6%	84.7%	95.3%	68.5%
Jun-16	West	Cherry	1187.7	1173.2	950.5	933	655.5	632.5	927.5	893	98.8%	98.2%	96.5%	96.3%
Jul-16	West	Cherry	1287	1296	1062.5	1056.04	770.5	736	966	966	100.7%	99.4%	95.5%	100.0%
Aug-16	West	Cherry	1191.5	1163	1056	1056	736	725.5	977.5	957	97.6%	100.0%	98.6%	97.9%
Sep-16	West	Cherry	1096	1038.5	1011	1015	736	732.5	851	862.5	94.8%	100.4%	99.5%	101.4%
Oct-16	West	Cherry	1448	1425	975.5	954.5	724.5	728.5	1023.5	1002.5	98.4%	97.8%	100.6%	97.9%
May-16	West	Eastway A&T	1227	1117	883.5	873.5	593	592.5	720.5	719.5	91.0%	98.9%	99.9%	99.9%

Jun-16	West	Eastway A&T	1294	1186	906	837	582.5	508	1062	1062	91.7%	92.4%	87.2%	100.0%
Jul-16	West	Eastway A&T	998	888	1021	952	632.5	636.5	990.5	944.5	89.0%	93.2%	100.6%	95.4%
Aug-16	West	Eastway A&T	1152.5	1155.5	1142	1126.5	690	667	934.4	922.9	100.3%	98.6%	96.7%	98.8%
Sep-16	West	Eastway A&T	1155.5	1132.5	954	911.5	567.5	567.5	996.5	996.5	98.0%	95.5%	100.0%	100.0%
Oct-16	West	Eastway A&T	1146.5	1109	973.5	965	586.5	586.5	1150	1150	96.7%	99.1%	100.0%	100.0%
May-16	West	Juniper	1633.5	1586	1034	965.1	713	713	828	828	97.1%	93.3%	100.0%	100.0%
Jun-16	West	Juniper	1599.5	1533	931.5	918	713	689	667	666	95.8%	98.6%	96.6%	99.9%
Jul-16	West	Juniper	1337	1238.5	1194	1165	678.5	678.5	713	713	92.6%	97.6%	100.0%	100.0%
Aug-16	West	Juniper	1286	1243	989	962	701.5	701.5	690	671.5	96.7%	97.3%	100.0%	97.3%
Sep-16	West	Juniper	1269.5	1235	962.5	924	709.5	707.5	747.5	747.5	97.3%	96.0%	99.7%	100.0%
Oct-16	West	Juniper	1326	1286.5	946	923.5	690	678.5	790	767	97.0%	97.6%	98.3%	97.1%
May-16	West	Maple Ward	1104.5	1046.5	1472	1427	540.5	529	943	920	94.7%	96.9%	97.9%	97.6%
Jun-16	West	Maple Ward	1085	1029.5	1242	1115.5	425.5	425.5	977.5	989	94.9%	89.8%	100.0%	101.2%
Jul-16	West	Maple Ward	985.5	917.5	1334	1219	540.5	494.5	920	897	93.1%	91.4%	91.5%	97.5%
Aug-16	West	Maple Ward	889.5	866.5	1587	1518	471.5	414	954.5	977.5	97.4%	95.7%	87.8%	102.4%
Sep-16	West	Maple Ward	1035	1042.5	1587	1541	448.5	448.5	1253.5	1253.5	100.7%	97.1%	100.0%	100.0%
Oct-16	West	Coral	1089	1008.5	1375	1363.5	529	506	1150	1138.5	92.6%	99.2%	95.7%	99.0%
May-16	West	Pine Lodge	985.5	869.5	1184.5	1104	529	494.5	1081	1046.5	88.2%	93.2%	93.5%	96.8%
Jun-16	West	Pine Lodge	963	968	1173	1150	529	529	908.5	897	100.5%	98.0%	100.0%	98.7%
Jul-16	West	Pine Lodge	1009.5	1011.5	1138.4	1092.5	529.034	529	1035	1012	100.2%	96.0%	100.0%	97.8%
Aug-16	West	Pine Lodge	1047	1035.5	1245.5	1199.5	483	483	1000.5	989	98.9%	96.3%	100.0%	98.9%
Sep-16	West	Pine Lodge	1042	1042	1403	1380	609.5	609.5	1092.5	1092.5	100.0%	98.4%	100.0%	100.0%
Oct-16	West	Indigo	1231.5	1164.5	1012	931.5	575	575	966	920	94.6%	92.0%	100.0%	95.2%
May-16	West	Rosewood	1010	845	1376.5	1293.5	379.5	379.5	805	801	83.7%	94.0%	100.0%	99.5%
Jun-16	West	Rosewood	995.5	888.5	1372	1223.5	372	372	713	690	89.3%	89.2%	100.0%	96.8%
Jul-16	West	Rosewood	1006.5	900.5	1521	1457.5	513	490	848.5	817.5	89.5%	95.8%	95.5%	96.3%
Aug-16	West	Rosewood	1095.5	1079	1330	1299.5	494.5	460	952	946	98.5%	97.7%	93.0%	99.4%
Sep-16	West	Rosewood	1060.5	994.5	1220	1194.5	483.5	483.5	925.5	900	93.8%	97.9%	100.0%	97.2%
Oct-16	West	Rosewood	1098	1055.5	1449	1403	437	425.5	1012	1012	96.1%	96.8%	97.4%	100.0%
May-16	Wirral	Brackendale	1087	1049.5	856.5	857.5	712.5	713.5	702	691	96.6%	100.1%	100.1%	98.4%
Jun-16	Wirral	Brackendale	1222.4	1117	684	684	714	714	679	679	91.4%	100.0%	100.0%	100.0%
Jul-16	Wirral	Brackendale	1020	956.5	931.5	862.6	724.5	701.5	690	644	93.8%	92.6%	96.8%	93.3%
Aug-16	Wirral	Brackendale	970	949.5	924	924	678.5	632.5	770.5	770.5	97.9%	100.0%	93.2%	100.0%
Sep-16	Wirral	Brackendale	1028	1024.5	783	731	724.5	678.5	655.5	667	99.7%	93.4%	93.7%	101.8%
Oct-16	Wirral	Brackendale	1058.5	1058.5	828	805	724.5	713	713	708	100.0%	97.2%	98.4%	99.3%
May-16	Wirral	Brooklands	1038.5	903	1490.5	1517.5	722	670	1097.5	1161.5	87.0%	101.8%	92.8%	105.8%
Jun-16	Wirral	Brooklands	1188.5	967.5	1375	1351	675	608	1029	1102	81.4%	98.3%	90.1%	107.1%
Jul-16	Wirral	Brooklands	1150	1059	1311.75	1058.25	713	713	368	345	92.1%	80.7%	100.0%	93.8%
Aug-16	Wirral	Brooklands	1879	1646	2772	2681	717	633	954	963	87.6%	96.7%	88.3%	100.9%
Sep-16	Wirral	Brooklands	1141	953	1329	1335	698	666	1013	1016	83.5%	100.5%	95.4%	100.3%
Oct-16	Wirral	Brooklands	1074.5	924.5	1404.5	1241.5	722	650	1090	1018	86.0%	88.4%	90.0%	93.4%
May-16	Wirral	Lakefield	998.5	964	1091	996	718	703.5	713	724.5	96.5%	91.3%	98.0%	101.6%
Jun-16	Wirral	Lakefield	1174.5	1184.5	1105	997	690	679	679	657	100.9%	90.2%	98.4%	96.8%
Jul-16	Wirral	Lakefield	2145	1855	2740	2628	717	639.5	1118	1117	86.5%	95.9%	89.2%	99.9%
Aug-16	Wirral	Lakefield	939.5	939.5	999.5	976.5	713	690	678.5	632.5	100.0%	97.7%	96.8%	93.2%
Sep-16	Wirral	Lakefield	930.5	919	1038	980.5	678.5	540.5	690	736	98.8%	94.5%	79.7%	106.7%
Oct-16	Wirral	Lakefield	1012.5	960.5	1018	995	727	692.5	720	708.5	94.9%	97.7%	95.3%	98.4%
May-16	Wirral	Meadowbank	892	947.5	1893.5	1870.5	675.5	675.5	1382	1301	106.2%	98.8%	100.0%	94.1%
Jun-16	Wirral	Meadowbank	915.5	840.5	1423.5	1331.5	635	608	975.5	844	91.8%	93.5%	95.7%	86.5%
Jul-16	Wirral	Meadowbank	1107.5	1084.5	876.5	738	713	690	667	597.5	97.9%	84.2%	96.8%	89.6%
Aug-16	Wirral	Meadowbank	1032.5	987.5	1580.5	1551.5	586.5	563.5	1130	1049	95.6%	98.2%	96.1%	92.8%
Sep-16	Wirral	Meadowbank	900.5	881.5	1659	1613	644	644	1081	1069.5	97.9%	97.2%	100.0%	98.9%
Oct-16	Wirral	Meadowbank	1058	1058	1493.5	1436	690	667	1092.5	1081	100.0%	96.1%	96.7%	98.9%
May-16	Wirral	Oaktrees	1267	1185	1549.5	1354	713	702	386.5	375.5	93.5%	87.4%	98.5%	97.2%
Jun-16	Wirral	Oaktrees	1261.5	1237.5	2174	1290	690	702	427	393	98.1%	59.3%	101.7%	92.0%
Jul-16	Wirral	Oaktrees	1037.5	988.5	1670.9	1608	690	690	1184.5	1173	95.3%	96.2%	100.0%	99.0%
Aug-16	Wirral	Oaktrees	1044	996	1192	1157.5	722.5	619	356.5	356.5	95.4%	97.1%	85.7%	100.0%
Sep-16	Wirral	Oaktrees	1064.5	972.5	1291.5	1061	690	644	345	345	91.4%	82.2%	93.3%	100.0%
Oct-16	Wirral	Oaktrees	1075.75	884.25	1288	1207.5	713	701.5	376	284	82.2%	93.8%	98.4%	75.5%
May-16	West	Willow PICU	1046.5	982	1050	1061.5	724.5	713	747.5	724.5	93.8%	101.1%	98.4%	96.9%
Jun-16	West	Willow PICU	1007.5	982.5	966	920.5	667	659.5	724.5	724.5	97.5%	95.3%	98.9%	100.0%
Jul-16	Wirral	Willow PICU	1033.5	1035.5	1159	1159	782	777.5	816.5	809	100.2%	100.0%	99.4%	99.1%
Aug-16	Wirral	Willow PICU	1090.5	1097	1023.5	1012	693.5	626.5	839.5	828	100.6%	98.9%	90.3%	98.6%
Sep-16	Wirral	Willow PICU	1128	1056.25	1081	1000.5	739.5	731	782.5	829	93.6%	92.6%	98.9%	105.9%
Oct-16	Wirral	Willow PICU	1186.5	1201.5	874	839.5	736	720	770.5	746.5	101.3%	96.1%	97.8%	96.9%

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Ward Daily Staffing Levels November and December Data 2016
Agenda ref. no:	16-17-116b
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	25/01/2017
Presented by:	Avril Devaney, Director of Nursing, Therapies and Patient Partnership

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	No
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	No
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	No
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
35T	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
35T	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*

This report details the ward daily staffing levels during the month of November and December 2016 following the submission of the planned and actual hours of both registered nurses (RN) and clinical support workers (CSWs) to UNIFY (appendix 1). The themes arising within these monthly submissions continue to mirror those that have arisen previously. These themes identify how patient safety is being maintained on a shift by shift basis.

Background – *contextual and background information pertinent to the situation/ purpose of the report*

The monthly reporting of daily staffing levels is a requirement of NHS England and the National Quality Board in order to appraise the Board and the public of staffing levels within in-patient units.
A number of recommendations were made within the latest six monthly report including consistency checking, national benchmarking, and widening the consideration of the MDT role within safer staffing. These recommendations are currently being followed through and monitored via the Safer Staffing group led by the Associate Director of Nursing [MH and LD] and are reported on in the next 6 monthly report.

Assessment – *analysis and considerations of options and risks*

During November 2016 the trust achieved staffing levels of 95.2% for registered nurses and 94.9% for clinical support workers on day shifts and 95.7% and 95.7% respectively on nights.

During December 2016 the trust achieved staffing levels of 94.7% for registered nurses and 92.4% for clinical support workers on day shifts and 94.9% and 95.4% respectively on nights.

To note:

- The staffing levels on Croft Ward fell below expected variation, to 86.1% for November; and
- The staffing levels on three wards fell below expected variation. Croft Ward, at 86.1%, Saddlebridge at 86.7%, and Lime Walk House at 87.3% due to high sickness and cross cover.

Where 100% fill rate was not achieved patient safety on in-patient wards was maintained by nurses working additional unplanned hours, cross covering across wards, the multi-disciplinary team and ward manager supporting nursing staff in the delivery of planned care and patient care being prioritised over non-direct care activities. Appendix 1 and 2 details how wards, who did not achieve overall staffing of 95%, maintained patient safety.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*

The Board of Directors are recommended to note the report.

Who/ which group has approved this report for receipt at the above meeting?	Avril Devaney, Director of Nursing, Therapies and Patient Partnership
Contributing authors:	Anne Casey, Head of Performance and Information

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Gary Flockhart, Associate Director of Nursing [MH and LD] Avril Devaney, Director of Nursing, Therapies and Patient Partnership	17/01/2017

Appendices provided for reference and to give supporting/ contextual information:
Provide only necessary detail, do not embed appendices, provide as separate reports

Appendix no.	Appendix title
1	Ward Daily Staffing November 2016
2	Ward Daily Staffing December 2016

	Ward	Day				Night				Fill Rate				Safe Staffing was maintained by:
		Registered		Care Staff		Registered		Care Staff		Day		Night		
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	
East	Adelphi	1296	1192	963.25	927.75	724.5	713	1173	1069.5	92.0%	96.3%	98.4%	91.2%	Altering skill mix. Staff cross covered other wards. Nursing staff working additional unplanned hours.
	Alderley Unit	926	840.5	1426	1315	678.5	598	701.5	736	90.8%	92.2%	88.1%	104.9%	Altering skill mix. Nursing staff working additional unplanned hours.
	Bollin	1278.5	1257	1305	1307	770.5	748.5	1352	1321	98.3%	100.2%	97.1%	97.7%	*
	CARS	867	782	996.5	858	667	622.8	402.3	458.8	90.2%	86.1%	93.4%	114.0%	Altering skill mix. Staff cross covered other wards. Nursing staff working additional unplanned hours.
	Croft	1153.5	1029	1537	1298.5	701.5	627	1570.1	1315.6	89.2%	84.5%	89.4%	83.8%	Staff cross covered other wards. Altering skill mix. Ward Manager working in the clinical team. Nursing staff working additional unplanned hours.
	Greenways A&T	1183	1047	1872.5	1705	690	529	1345.5	1316.5	88.5%	91.1%	76.7%	97.8%	Staff cross covered other wards. Altering skill mix. Ward Manager working in the clinical team. Nursing staff working additional unplanned hours.
	LimeWalk Rehab	1161.5	927.5	892.04	863.5	688.5	665.73	724.5	650	79.9%	96.8%	96.7%	89.7%	Altering skill mix. Staff cross covered other wards.
	Saddlebridge	1006	1001.5	1259	1259	609.5	618	828	759.5	99.6%	100.0%	101.4%	91.7%	*
Wirral	Brackendale	1112	1068.5	874.5	863	713	713	678.5	678.5	96.1%	98.7%	100.0%	100.0%	*
	Brooklands	1089	1055.5	1155	1130	698	698	915	892	96.9%	97.8%	100.0%	97.5%	*
	Lakefield	1039.5	1038.5	920	920	700	688.5	690	609.5	99.9%	100.0%	98.4%	88.3%	Staff cross covered other wards. Nursing staff working additional unplanned hours.
	Meadowbank	1094	1082.5	1523	1503.5	690	690	1226	1191.5	98.9%	98.7%	100.0%	97.2%	*
	Oaktrees	1011.5	950.5	1430.5	1326.5	690	563.5	345	333.5	94.0%	92.7%	81.7%	96.7%	Altering skill mix. Staff cross covered other wards. Nursing staff working additional unplanned hours.
	Willow PICU	1197.75	1177.25	785	770.5	713	693.5	713	735.5	98.3%	98.2%	97.3%	103.2%	*
West	Beech	1400.5	1373.5	1023.5	926.5	670	658.5	719	681.5	98.1%	90.5%	98.3%	94.8%	Staff cross covered other wards. Altering skill mix. Nursing staff working additional unplanned hours.
	Cherry	1418.25	1413.5	832	826	747.5	718.5	954.5	897	99.7%	99.3%	96.1%	94.0%	*
	Eastway A&T	817	787.5	1118.5	1095.5	648	636.5	954.5	954.5	96.4%	97.9%	98.2%	100.0%	*
	Juniper	1475.5	1399	963	879.5	687	677	711.5	652	94.8%	91.3%	98.5%	91.6%	Altering skill mix. Staff cross covered other wards. Nursing staff working additional unplanned hours.
	Coral	972	968.5	1265	1175	483	506	966	954.5	99.6%	92.9%	104.8%	98.8%	*
	Indigo	1029	1025.5	1150	1091	552	552	862.5	828	99.7%	94.9%	100.0%	96.0%	*
	Rosewood	1045.5	1022.5	1135.5	1135.5	502.5	502.5	874	874	97.8%	100.0%	100.0%	100.0%	*
	Trustwide	**23573**	**22439.25**	**24426.79**	**23176.25**	**14024**	**13419.53**	**18706.4**	**17908.9**	**95.2%**	**94.9%**	**95.7%**	**95.7%**	

	Ward	Day				Night				Fill Rate				Safe Staffing was maintained by:
		Registered		Care Staff		Registered		Care Staff		Day		Night		
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	
East	Adelphi	1264.75	1092.25	1184	1099.5	717.5	717.5	1253	1099.5	86.4%	92.9%	100.0%	87.7%	Altering skill mix. Staff cross covered other wards.
	Alderley Unit	1092	1018	1390.5	1224.5	713	713	713	690	93.2%	88.1%	100.0%	96.8%	Altering skill mix. Staff cross covered other wards. Nursing staff working additional unplanned hours.
	Bollin	1262	1262	1473	1484.5	770.5	774.5	1476.5	1495	100.0%	100.8%	100.5%	101.3%	*
	CARS	236.5	227.5	264.5	232.5	161	149.5	115	92	96.2%	87.9%	92.9%	80.0%	Staff cross covered other wards.
	Croft	1054.5	870.5	1717.5	1394.5	747.5	575	1453	1318.5	82.6%	81.2%	76.9%	90.7%	Staff cross covered other wards. Altering skill mix. Ward Manager working in the clinical team. Nursing staff working additional unplanned hours.
	Greenways A&T	1123.2	1049.45	1835.5	1441.65	713	736	1345.5	1161.5	93.4%	78.5%	103.2%	86.3%	Staff cross covered other wards. Altering skill mix. Ward Manager working in the clinical team. Nursing staff working additional unplanned hours.
	LimeWalk Rehab	1165.5	833	1075.4	1004.5	690	667	770.5	726	71.5%	93.4%	96.7%	94.2%	Altering skill mix. Staff cross covered other wards.
	Saddlebridge	994.5	930.75	1529.5	1383.5	753.5	615.5	954.5	740.5	93.6%	90.5%	81.7%	77.6%	Altering skill mix. Staff cross covered other wards. Nursing staff working additional unplanned hours.
Wirral	Brackendale	1080	1084	900.5	860.75	713	701.5	713	713	100.4%	95.6%	98.4%	100.0%	*
	Brooklands	1003.5	947.5	1238	1230	718	689	1129	1118	94.4%	99.4%	96.0%	99.0%	Staff cross covered other wards. Ward Manager working in the clinical team. Altering skill mix.
	Lakefield	975.75	915.75	1017	925	713	575	705.5	717.1	93.9%	91.0%	80.6%	101.6%	Staff cross covered other wards. Nursing staff working additional unplanned hours.
	Meadowbank	1127.9	1116.4	1482.5	1381	690	678.5	1161.5	1161.5	99.0%	93.2%	98.3%	100.0%	*
	Oaktrees	1082	1070.5	1180	1139	690	598	379.5	414	98.9%	96.5%	86.7%	109.1%	Altering skill mix. Staff cross covered other wards. Nursing staff working additional unplanned hours.
	Willow PICU	1196	1220.5	782	740.5	713	724.5	724.5	701.5	102.0%	94.7%	101.6%	96.8%	*
West	Beech	1481.5	1467.5	1009	966	701.5	667	724.5	672	99.1%	95.7%	95.1%	92.8%	Staff cross covered other wards. Altering skill mix. Nursing staff working additional unplanned hours.
	Cherry	1292.25	1219.25	975	899	768.5	731	943	862.5	94.4%	92.2%	95.1%	91.5%	Staff cross covered other wards. Nursing staff working additional unplanned hours.
	Eastway A&T	946	907.5	1091	1048.5	586.5	540.5	1046.5	1046.5	95.9%	96.1%	92.2%	100.0%	Staff cross covered other wards. Nursing staff working additional unplanned hours.
	Juniper	1418.5	1368	861.5	797.5	621	621	786	769	96.4%	92.6%	100.0%	97.8%	Altering skill mix. Staff cross covered other wards. Nursing staff working additional unplanned hours.
	Coral	1062	1043	1368.5	1302.5	589.5	589.5	1218.5	1218.5	98.2%	95.2%	100.0%	100.0%	*
	Indigo	1057	1034	1149	1114.5	667	667	920	920	97.8%	97.0%	100.0%	100.0%	*
	Rosewood	941.5	971.5	1331.5	1293.5	491	491	897	897	103.2%	97.1%	100.0%	100.0%	*
	Trustwide	**22856.85**	**21648.85**	**24855.4**	**22962.9**	**13928**	**13221.5**	**19429.5**	**18533.6**	**94.7%**	**92.4%**	**94.9%**	**95.4%**	

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

REPORT DETAILS

Report subject:	Learning from Experience report – trimester 2 2016/17
Agenda ref. no:	16/17/117
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and approval
Date of meeting:	25/01/2017
Presented by:	Avril Devaney Director of Nursing, Therapies & Patient Partnership

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	No
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	No
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	Yes
All clinical strategic risks	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
N/A	

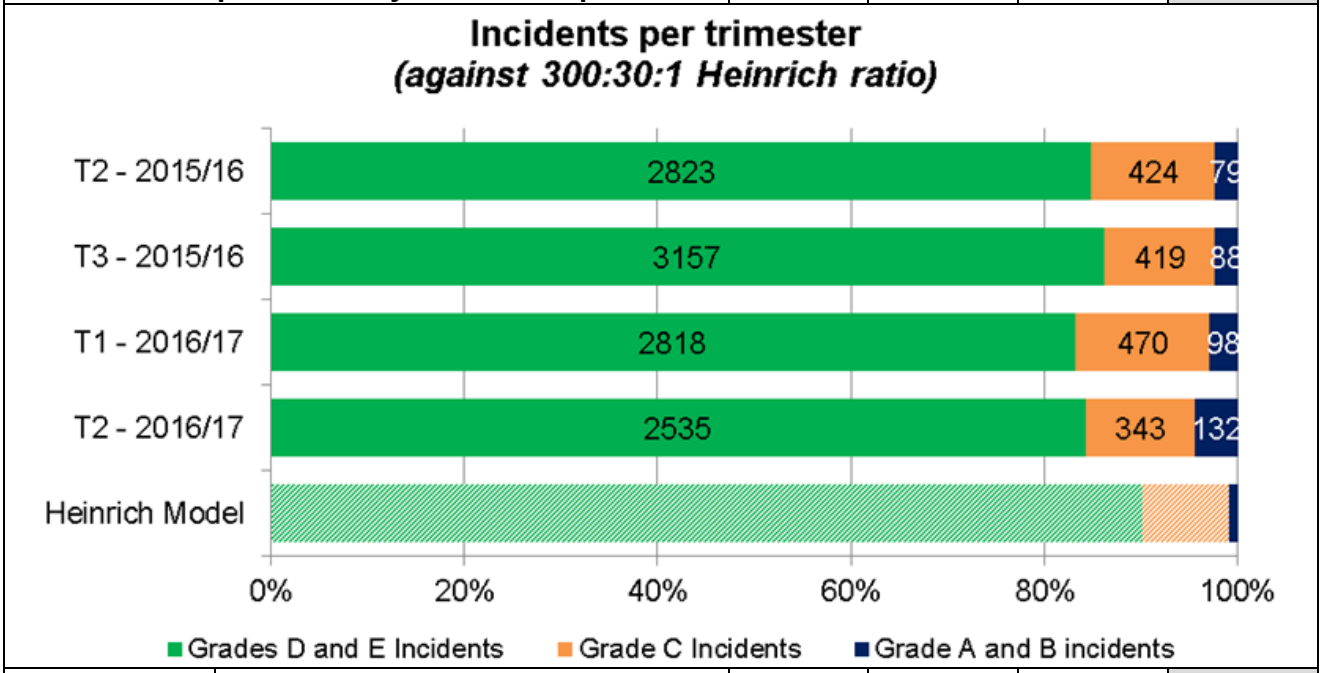
REPORT BRIEFING

1. Situation

This Learning from Experience report aggregates qualitative and quantitative analysis from key sources of feedback from people who access the Trust's services and people who deliver the Trust's services, and other relevant sources of learning, covering the period from August 2016 to November 2016, trimester 2 of 2016/17. The report compares current performance across a four trimester time series to mitigate seasonal variations, whilst also facilitating the identification of potential triggers to detect and prevent incidents by comparing current performance with the previous trimester.

2. Background – Key performance indicators

Performance indicator			2015/16		2016/17	
			T1	T2	T3	T1
Number of patient safety incidents reported			3326	3664	3386	**3010**



External reporting	National Reporting and Learning System		1336	1652	1790	**1418**
	NHS Litigation Authority	Non clinical claims	7	1	8	**4**
		Clinical claims	2	2	2	**0**
Number of complaints			87	116	90	**124**
Acknowledgement of complaints within 3 days			100%	100%	100%	**100%**
Number of compliments			1503	1116	1267	**987**

All incident and compliment numbers represent a snapshot at the time of publication of the report and are subject to change over time, for example: re-categorisation of incidents following receipt of further information since the previous report, receipt of compliments retrospectively.

3. Assessment

3.1 Incident reporting

Whilst analysing the last four trimesters of incident reports, the Heinrich ratio for CWP continues to display a combined decrease in the proportion of category C – E incidents (moderate/ lower/ no harm). As well as scope to improve the ratio of level of harm incidents, there is also scope to improve reporting of all numbers of categories of incidents. Since the publication of the "Mazar's" report into the deaths of people with a learning disability or mental health problem, and the Trust's continuous improvement plan to respond to the themes in the *Care Quality Commission*'s report "Learning, candour and accountability" (specifically 'identification and reporting' and 'decision to review or investigate') there has been an overall increase in the reporting of category A and B incidents (severe harm) [*n* = 132]. Using these criteria to aid decision making, 52% of these incidents were considered as not meeting the criteria of the *NHS England* serious incident framework. Further, 69 serious incidents were reported to StEIS, a seasonal trend (the highest since the equivalent trimester 2 in 2015/16), which is indicative of a more positive approach that the Trust is now considering more serious incidents for internal review or investigation. An action has been identified to explore this further to provide assurance around good practice and areas requiring improvement. The top ranking incident category remains self-harm in trimester 2, although there is only a small increase of 17 incidents. All other top ranking categories have

decreased in terms of their numbers of reports, with the exception of the medication category, which has seen an increase in reporting of 18%. The Quality Committee received an analysis of these incidents in more detail.

3.2 Falls related incidents

There has been a Trustwide decrease in the reported number of falls this trimester from 206 to 163. Analysis of the severity of the falls incidents demonstrates that the most frequently reported category, as is the preferred profile, is grade E (no harm) [*n* = 91], followed by grade D (low harm) [*n* = 59]. There was one grade A fall and three grade B falls incidents. Further analysis has not identified any trends in relation to these incidents and they are being investigated as per policy. Quality improvement work is continuing (in both inpatient and community settings) in line with the Trust's Zero Harm continuous improvement plans. The effectiveness of this ongoing work is being tracked by the Quality Committee and is receiving senior oversight through the risk treatment plan identified in the strategic risk register.

3.3 Incidents associated with the management of challenging behaviour

In trimester 2, the number of prone position restraint incident reports has continued to sustain improvements made during 2015/16 since the implementation of the Trust's quality improvement project to accelerate restraint reduction. Furthermore, there is continuing clear evidence that staff are progressively using more de-escalation techniques to manage challenging behaviour before it escalates to the need for use of physical restraint. It is important, as part of continuous quality improvement principles, to measure and monitor incident reports for any early warnings. This is being achieved through an analysed Trust and ward level data set provided to all wards each quarter.

3.4 Feedback from people who access the Trust's services

124 complaints were received under the NHS complaints procedure during this trimester. Of these, they were received per locality as follows: CWP East 33 complaints, CWP West 47 complaints, CWP Wirral 38 complaints and 6 for Corporate Support Services. Further analysis regarding complaints was received by the Quality Committee.

This trimester there has been an increase of PALS contacts to 71 contacts compared with 70 in trimester 1. The PALS function has now moved to the Patient and Carer Experience Team, which includes the additional role of Carer Advice and Liaison Service (CALS) Officer. The complaints team have provided training and support to transition the service to continue the work of early resolution and ensuring that concerns which are raised are dealt with quickly.

4. Recommendation

4.1 Recommendations from trimester 2 analysis

These recommendations have been identified from the detailed analysis of learning from experience that is received by the Quality Committee. Updates and assurances received against these recommendations will be presented in the next trimesterly report to the Board of Directors.

4.1.1 The incidents team to support team managers in feeding back incidents to reporters to encourage incident reporting:
i) Incidents Manager to work with the Communications team to promote the reporting of incidents.
ii) Incidents Manager to work with the Trust's incident reporting system provider to update the system to enable it to provide individual feedback for each incident reported to encourage further reporting.

4.1.2 The Quality Surveillance team to analyse emerging increases in serious incidents being reported to StEIS and produce a report in April 2017 (trimester 3 reporting) to identify good practice and inform any actions.

4.1.3 The Quality Surveillance team should consider including monitoring of inquest conclusions from the Coroner as a key measure of success of the sensitivity of the learning themes quality improvement project.

4.1.4 The Quality Surveillance team should consider scope to include, as part of learning themes reviews (using quality improvement in the falls theme), intelligence judgements around reductions in incident reporting associated with quality improvement interventions and whether these are attributable to interventions reducing incidence of potential/ actual harm.

4.1.5 Following the completion of three current serious incident investigations in relation to falls, the Head of Clinical Governance to undertake a cluster review to identify any themes and incorporate the findings into the quality improvement work for falls.

4.1.6 A nominated person to be identified, from Brooklands and Willow wards, to reflect on and identify mitigations to the variations in practice that are apparent in the data, or to demonstrate that the benchmarking between the two teams is limited due to unwarranted comparison. Irrespective, reflective practice across both wards should be undertaken to understand best practice in place on each ward that can be transferred or translated to the other ward.

4.1.7 The Safe Services Department should develop a clinical escalation policy (in conjunction with Consultant managers) to support consensus decision making where individual/ team clinical and professional judgement in relation to complex cases of care requires further opinion.

4.1.8 NHS Litigation Authority data indicates that about a quarter of claims commence with an incident or a complaint. To understand and improve the Trust's position (with the aim of improving patient safety and quality), the Incidents team should:
i) Develop a key performance indicator for inclusion in the Learning from Experience report to consider CWP complaints and incidents to claims conversion rate.
ii) Link with the Quality Surveillance team to incorporate team level claims data from the NHS Litigation Authority scorecard into locality data packs.

4.2 Updates and assurances received against trimester 1 recommendations

Through the team-level Locality Data Pack framework, the Safe Services Department should identify teams with scope to improve lower/ no harm reporting and in doing so, identify any support teams require to facilitate this. The recent Patient Safety & Effectiveness Sub Committee workshops have suggested that capacity to report incidents is lower and could be better encouraged through consistent feedback being provided by team managers for every incident reported. This should be considered by the incidents team in conjunction with operational managers via locality governance meetings.
The Incidents team produce a weekly report displaying lessons learned from each incident that has been given final approval. The report is shared with Clinical Service Managers to help team managers to provide feedback to staff reporting the incident. The Incidents Manager is working with the Trust's incident reporting system provider and the CWP IT service desk to produce an automated email to notify the person reporting an incident that the incident has been reviewed and lessons learned have been recorded. This does not deflect the team manager discussing the incident with the reporter for individual learning. Safe Services Department representatives have promoted the reporting of low/ no harm incidents throughout patient safety improvement reviews, at Zero Harm meetings, Learning from Experience meetings, clinical and leadership meetings and the Medication Sub Committee. There are recommendations for the Incidents Manager to work closely with low reporting teams to improve the number of low/ no harm incidents reported.
The Head of Clinical Governance should provide a summary of the outputs from the suicide prevention workshop, which is due to take place in September 2016, linking to the Trust's

approach to Zero Harm and how this specifically relates to the reporting and management of self-harm incidents.
The suicide prevention workshop commenced with a powerful talk from a survivor of suicide bereavement and the importance of support, identifying the risks of suicide and postvention support for those who have to deal with the impact and aftermath of suicide. Over 80 people attended the day, the workshops identified the need for suicide intervention training, supporting staff to recognise the signs of suicidal intent, to ensure staff were equipped with the skills to intervene therapeutically and confidently, further to support them to have conversations with patients and their carers. The workshops reviewed what the Trust did well, this included passion for the work it does, team work, good multi-agency working, areas of excellence around safety planning with patients and appropriate risk assessment, including positive risk assessment. Staff and service users then focused on areas that could be improved, these included equity of care and resources across all localities, a more standardised approach to the care that the Trust delivers and to be able to measure outcomes, streamlined documentation and IT systems, and further support to teams to build resilience. The barriers to the implementation of these were considered and included pressures on time and resources, fragmented services and competing priorities. The building blocks for the strategy were agreed upon at the workshop, areas of focus will be on improving the assessment of patients who are at risk, and therefore the management of suicide prevention, ensuring all staff have the appropriate training, that practice is evidence based and is sustained. Also the Trust will review how it will transform services to ensure that best practice is implemented, for example the 'perfect depression model'. The workshop highlighted the need for all stakeholders to work together, this would help to maximise economies of scale and reduce duplication of effort, share specialist expertise, to innovate and learn together and share best practice. This will ensure that suicide prevention is everyone's business and not just specialist mental health services.
The Heads of Clinical Governance and Effectiveness should consider, as part of their meeting scheduled in September to develop a business cycle for the Patient Safety & Effectiveness Sub Committee to prioritise key risks and clinical standards of care requiring review, including the 'staffing', 'care planning' and 'risk management' learning themes.
The business cycle is currently being developed, these are being aligned with the Trust's priorities which will be outlined in the Business Strategy. The focus is to ensure that there are consistent clinical standards across all services, that any variances to these standards will be identified with actions identified to reduce harm, reviewed within the Patient Safety and Effectiveness Sub Committee. The Heads of Clinical Governance and Effectiveness are meeting with each locality in order to map out their current services, pathways and outcome measures, identify the gaps and identify any risks associated with these gaps. Together with the clinical teams, plans will be developed, with clear outcome measures, timeframes and those responsible for meeting these.
The incidents team to facilitate ongoing discussion with specialist teams, such as tissue viability (in the first instance) and its commissioners to work towards agreeing application of person centred principles into all aspects of incident reporting.
The reflective review template has been improved to include a section on Duty of Candour. The tissue viability team now records the explanation provided to patients and families regarding why they are reviewing their/ their relative's pressure ulcer care and gives them an opportunity to be involved in the review and to ask questions.
The Associate Director of Nursing & Therapies (Mental Health), as part of his walkround programme across the Trust and the continuous service improvement forum, to work with Matrons to identify PDSA approaches to further improve learning from prone position restraints – particularly those reported by Bollin, Brooklands and Saddlebridge wards.
Actions to debate this have since been identified within the "reducing the use of physical restraint" quarterly report, including discussion at a future inpatient service improvement forum. Further, a refined action has been identified in section 4.1 of this report.
The incidents team to meet with the Medicines Safety Pharmacist and Safety & Security Lead to discuss their current role in reviewing incidents relating to their specialism and how this can be strengthened.
The Incidents Manager and Medication Safety Officer have met regularly to review medication

incidents. As a result, they have revised the medication categories and sub categories on the incident reporting system to directly link to NRLS codes. This will provide further clarity of the stage of care that the medication incident occurred and will be incorporated into analysis for the trimester 3 2016/17 Learning from Experience report. The Medication Safety Officer has been reviewing all incidents to be reported to NRLS. The Management of Violence and Aggression section on the Trust's incident reporting system has been reviewed; further discussions are ongoing regarding the Safety & Security Lead's approval of these incidents.
To raise through the local governance structures the benefits of 'investing' in communication with families (with patient consent) regarding plans of care, particularly around medication as a key treatment and offering consultation with a member of the care team where there are questions or concerns, thereby supporting local resolution rather than the complaint route at the outset.
Triangle of Care in all localities is continuously improving communications with families and carers by sharing and learning from best practice examples throughout the services and wards. Localities are encouraging personal interaction within the inpatient wards by providing specialised events for families and carers to attend, such as Carers Afternoon Tea, to receive personalised support. Positive feedback has been received, proving extremely beneficial to both families/ carers, professionals and people who access the Trust's services. CWP is also supporting the John's Campaign, launched by the family of a service user who had dementia. Wards have made several pledges to carers in how they intend to support their involvement in the care of the person who accesses CWP's services. The Carer Advice and Liaison Service Officer will continue to develop the Trust's support for carers.
To raise through local CAMHS governance structures the benefits of 'investing' in promotion of service offers and pathways with families and also professionals such as GPs, schools and local authorities.
This will be reviewed with the planned work over the coming months, commissioned by the Patient Safety & Effectiveness Sub Committee, in relation to demonstrating consistent standards of care and the implementation of robust care planning, for example through quality improvement approaches.
Head of Clinical Governance and the Claims Officer will undertake a review of the current claims score card to establish if the clinical claims received by CWP could have been forecasted. This will identify where there is scope to focus efforts in relation to triangulation of themes from incidents and complaints with claims.
Work has commenced and a further summary will be presented in trimester 3's report. For every new claim that is received, a report will be developed to identify the issue, what immediate learning there has been, this learning will be triangulated with the information available from incidents, complaints and inquests. If relevant, this learning will be shared with the relevant services. Further, once a claim has been closed, the same process will be followed. If anything new is identified that was not picked up at the initial review, the information will be triangulated once again. At the time of reviewing incidents and claims, the Head of Clinical Governance and Claims Officer are considering which may become a claim. Together with the Trust's Solicitors, the Trust is ensuring that it liaises with colleagues in the NHS Litigation Authority, this allows the Trust to be more proactive in applying for financial support for inquests, and it also means the Trust is proactively admitting liability where appropriate and can make early apologies to families. Further work is planned to be developed with this in 2017, as the Trust has a new working relationship and contract with the Trust's solicitors.

4.3 Recommendation to the Board of Directors

The Board of Directors is asked to **approve** the report and **endorse** the recommendations contained within.

Who/ which group has approved this report for receipt at the above meeting?	David Wood Associate Director of Safe Services
Contributing authors:	Audrey Jones, Head of Clinical Governance

		David Wood, Associate Director of Safe Services
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	Board of Directors	18/01/2017

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	CWP Mental Health Act annual activity/ compliance reporting (2015/16)
Agenda ref. no:	16/17/118
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and Approval
Date of meeting:	25/01/2016
Presented by:	Dr Anushta Sivananthan, Medical Director

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	No
Sustain financial viability and deliver value for money	No
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	No
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	No
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	Yes
Risk of breach of CQC regulation in respect of adherence to the Mental Health Act and lack of robust governance in relation to recommendations from CQC MHA commissioner visits.	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
N/A	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*

The purpose of this annual report is to update the Board of Directors in relation to:

1. The key findings and trends following Care Quality Commission (CQC) Mental Health Act (MHA) Reviewer visits, including a summary of national findings.
2. Hospital Managers' Panels.
3. Governance monitoring of the Mental Health Act, including MHA administrative provision in acute trusts.
4. Annual statistical benchmarking against the CQC Monitoring of the MHA 2015/16. (published 21 November 2016)

This annual report provides the Board of Directors with an update in relation to the key elements of Mental Health Act implementation within the Trust and highlights areas of progress.

Background – *contextual and background information pertinent to the situation/ purpose of the report*

The CQC use the MHA Code of Practice 2015 as guidance when undertaking visits to the Trust. During 2016, there were thirteen such visits to wards across the Trust. Actions plans developed in response to the findings of these and the themes identified are monitored by the MHA Team and reported quarterly to the Compliance, Assurance & Learning Sub Committee. See appendix 1.

The Hospital Managers' Panel reviews the validity of detentions under the MHA and has delegated powers to discharge patients if specific criteria are not met. The Code of Practice sets out guidance on how panels should be appointed and reviews conducted. During the past year, procedures have been improved to ensure Hospital Managers' Panels comply with this guidance. See appendix 2.

The use of MHA in acute trusts has posed issues of compliance with legislation and the Code of Practice. To safeguard patients and their rights, MHA administrative provision and support from CWP has been developed and agreed with two acute trusts. See appendix 3.

CWP continues to monitor the use of the MHA; a summary of use during 2015/16 is included in appendix 4 along with benchmarking with national statistics on the use of the Act.

Assessment – *analysis and considerations of options and risks*

MHA Reviewer visits. The CQC has identified a number of improvements, particularly in response to findings from the comprehensive inspection in 2015. In the main, these are procedural improvements that ensure compliance with the MHA Code of Practice. Continued support is provided by the MHA Team regarding understanding of the requirements of the Act, supported by a robust education and audit programme. The main improvement theme is the need to strengthen patient engagement; with the implementation of the Trust's new Person-centred Framework, this will facilitate improvements in this area.

Hospital Managers' Panel. During 2016, there were changes in the membership of the Panel to improve its diversity. Appraisal and education processes have been enhanced and a programme developed to further improve the functioning of the Panel, ensuring that members have the appropriate skills and experience and hearings are conducted in line with Trust and MHA guidance. To ensure appropriate future membership, a formal recruitment framework is in development.

MHA administration provision in acute trusts. Shortfalls in MHA governance in acute trusts has transpired, with requests for support from CWP, who now provide MHA administration and training to Mid Cheshire Hospitals NHS Foundation Trust and East Cheshire NHS Trust.

Benchmarking. Broadly speaking, the use of the Act within CWP is in line with use nationally. The main exception to this is in respect of the use of s.136 where, nationally, there is an increase of 18% but CWP has seen a decrease of 20%; indicating the effectiveness of improved working relationships with the police and the added value of the Street Triage teams.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*

The Board of Directors is asked to **discuss** and **approve** this report.

Who/ which group has approved this report for receipt at the above meeting?	David Wood, Associate Director of Safe Services
Contributing authors:	J Devine, E Fergusson, D Wood

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	J Devine to E Fergusson	11/01/2017
2	E Fergusson to D Wood	12/01/2017
3	D Wood to L Brereton for Board of Directors	16/01/2017

Appendices provided for reference and to give supporting/ contextual information:

Appendix no.	Appendix title
1	Key findings and trends following CQC MHA Reviewer visits
2	Hospital Managers' Panel update
3	Governance monitoring of the MHA
4	KP90 Annual Statistics/ CQC Annual Report Monitoring MHA 2015/16

16_17_118 Appendix 1

Key findings and trends following CQC MHA Reviewer visits during 2016

Issues identified

Category	Number of improvement actions required	% of improvements to actions completed
Inconsistent application of section 17 leave processes	**7**	**100%**
Inconsistent documentation of assessment of capacity	**6**	**100%**
Inconsistent documentation of record of rights	**4**	**100%**
Availability of MHA documentation (specifically AMHP reports)	**5**	**75%**
Inconsistent evidence of patient centred care and involvement	**11**	**100%**
Restrictive practices	**3**	**100%**
Unmet need	**3**	**100%**
Effectiveness of seclusion practices	**3**	**100%**
Environment, including quality of food	**1**	**100%**

Improvements have been made in respect of all actions identified, although the availability of AMHP reports continues to be an issue for some wards, as noted below. Further support and monitoring by the MHA Team will provide ongoing assurance that these improvements are sustained.

Breakdown of the number of actions identified per ward during 2016

EAST	Alderley	Bollin	Greenways	Limewalk	Adelphi	Croft
No. of actions	4	2	0	1	4	5
WEST	Rosewood	Pine Lodge	Eastway	Coral	Juniper	Willow
No. of actions	5	6	2	5	2	2
WIRRAL	Oaktrees					
No. of actions	5					

Response to actions, including MHA Team Locality Audits

The MHA Team, as part of their locality working, undertake a programme of ward and community team audits to monitor compliance with the Mental Health Act and, in particular, areas for improvement raised as part of CQC MHA Reviewer visits.

As a result of these findings, and those following CQC MHA Reviewer visits, two processes have been implemented by the MHA Team to improve compliance with the Code of Practice:

1. MHA documentation, including consent to treatment forms, are now attached to the electronic patient record (CAREnotes) following completion of the statutory scrutiny processes.
2. Capacity to consent to treatment is monitored upon receipt of a completed consent form. Where evidence is not found this is escalated as appropriate.

There are ongoing issues regarding the availability of AMHP reports following detention under the Act where the application has been made by a Cheshire East AMHP. Ongoing discussions are being held with the local authority to resolve this issue satisfactorily, progress with this is being monitored via the locality risk register process reported through to Operational Board.

The MHA Team will continue to support staff as well as undertake spot checks on wards as part of locality visits, with particular reference to the above themes; reporting to the Compliance, Assurance and Learning Sub Committee as appropriate.

CQC – Monitoring the Mental Health Act 2015/16

In November 2016, The CQC published their annual report on the use of the Mental Health Act; during 2015/16, they carried out 1,349 monitoring visits, and met with 4,282 patients. The key points of their findings are summarised below:

- Many examples of good practice have been seen throughout monitoring visits and inspections.
- In some areas that directly affect patients, families and carers, there has been little or no improvement, e.g. patients being informed of their right to an IMHA; patient involvement in care planning.
- Some providers are not doing enough to implement the Code of Practice 2015, or to inform patients of their rights. Fewer than half of the wards visited between September 2015 and April 2016 had provided training for staff or updated their policies and procedures to reflect the new guidance.
- One in ten records looked at did not show evidence that patients have had their rights explained to them at the point of detention.
- The ongoing increase in the number of uses of MHA may be due to less support being offered to keep patients out of an acute crisis and out of hospital. It may also be related to repeated admissions of the same patient on a rapid cycle.
- Issues which arose from visits to CAMHS included: a lack of patient involvement in care planning, lack of recording of consent and capacity, failure to provide information to patients regarding their rights and advocacy services.
- 11,991 SOAD visits during 2015/16 were to look at proposed medication treatment plans for detained patients, the highest number of visits recorded since 1985. However, the number of SOAD visits for CTO patients has declined by 12%. (A letter was received from CQC, dated 22 December, 2016, raising challenges in the low levels of recruitment of SOADs and requesting CWP's assistance in addressing these issues. This letter has also been sent to many other Trusts. The Trust will consider this request and formally respond, but will also discuss this with the CQC, and keep under review, in its routine relationship management meetings.)

<u>CWP position:</u>
Feedback from CWP's MHA Reviewer visits falls broadly in line with the issues reported with the CQC annual report. Over the past year the MHA Team have advised on specific improvement actions required following MHA Reviewer visits in order to resolve the issues and provide satisfactory feedback to the CQC, and assurance of compliance. The following actions have been undertaken by the MHA Team to maintain and sustain improvements:

- Continued support provided by the MHA Team regarding education and understanding of the requirements of the Act and Code of Practice.
- A robust monitoring programme has been implemented, findings cascaded and staff supported to resolve the issues
- Submission of CQC action plans following MHA Reviewer visits are consistently provided within timescales.
- MHA policies have been reviewed and updated to reflect the Code of Practice 2015.

<u>Good Practice recognition:</u>
CWP is cited on page 41 of the annual report as an example of good practice for the involvement of carers at Greenways. "We are particularly impressed with the way that one learning disability

unit involved both patients and carers in developing and implementing individualised programmes of care.”

16_17_118 Appendix 2

Hospital Managers' Panel Update

The Associate Hospital Managers are a group of independent volunteers who are appointed and trained by the Trust as lay persons. Their role is delegated from the Trust Board and acts as an independent safeguard of patients' rights. Duties include: review of a patient's detention at certain times (e.g. when a section is renewed), and review of detention following a patient appeal.

Over the past two years there have been some changes in the membership of the Panel. Seven panel members are no longer serving: four due to ill-health, two due to personal circumstances, and one following the outcome of an individual performance review. However eight new panel members have been appointed. The new panel members are from varying backgrounds, including previous First Tier Tribunal Panel members, social work, nursing and advocacy. This has provided a welcome diversity to the skills and experience of the Panel, bringing the membership up to 18. However, it has been acknowledged that consideration needs to be made for developing a recruitment process, particularly in view of the reported increase of 20% in the number of Hospital Managers' hearings held between 2015 to 2016 and the potential for this rise to continue.

The role of Non-Executive Director MHA Lead was handed over from Fiona Clark to Rebecca Burke-Sharples during 2016. Shortly after commencing this role, a review of the appraisal process was undertaken with the MHA Manager. The inaugural meeting of "Non- Executive Directors Review and Reflection of MHA Hospital Managers' Panels" took place on 19 December 2016. The purpose of this annual review is to provide assurance to the Board that governance procedures are in place, and that Hospital Managers' panels undertake their role within the remit of the MHA and Code of Practice. Actions agreed at this meeting included:

- Associate hospital manager appraisals to be undertaken by the Non-Executive Directors, incorporating feedback collated from monitoring processes implemented by the Mental Health Act Manager. Appraisals are to be held annually, however, appointment will be for a period of three years.
- The Mental Health Act Manager will share feedback with the Trust Chair to incorporate into NED appraisals.
- An induction programme to be introduced when new NEDs are appointed, including the appointment of peer mentors. The programme will also be applicable to new associate managers and will include a probationary period of three months, confirmation of appointment then being subject to feedback and interview with the NED MHA Lead.
- Training for both associate managers and NEDs will be provided as a minimum of twice a year to ensure personal development and to provide any applicable updates in caselaw, guidance etc. Suggested topics for future sessions have already been noted.
- A recruitment procedure is to be developed for associate hospital managers.

Two training sessions have been held during 2016 for Hospital Managers' Panels:

- Equality and Diversity facilitated by the Trust's Equality & Diversity Co-ordinator.
- The Decision Making process, co-facilitated by Hill Dickinson and the MHA Manager.

In addition, to assist the hospital managers in their role, a handbook has been developed by the MHA Manager to provide relevant guidance and a glossary of terminology. This will distributed by the end of February to all associate managers and NEDs by the MHA Team.

16_17_118 Appendix 3

Improving Governance Monitoring of the Mental Health Act

Learning from actions identified in the CQC Trustwide inspection of 2015, as well as ongoing CQC MHA Reviewer visits, continues to be incorporated into monitoring processes undertaken by the MHA Team. Essential Learning for MHA, and the Junior Doctors induction programme, have been updated, and bespoke training undertaken to support staff.

The MHA Team continues to attend ward and team meetings. In addition new monitoring processes have been introduced:

- Upon receipt of consent to treatment forms documentation by the RC of assessment of capacity to consent to treatment is monitored. Where no evidence is found, and if following a reminder to the RC this is still not evident, this is escalated to the relevant Clinical Director and an incident report completed.
- A quality assurance process has been introduced for Hospital Manager's hearings to monitor the effectiveness and quality of the Panels, and to identify any areas for improvement in the patient experience.

The MHA Team continue to support teams throughout the Trust, both in sustaining current improvements and to continue to accelerate further improvements. A programme of support visits by the MHA Team covering wards and community teams is ongoing, providing assurance of continued compliance. Mental Health Act activity is reported through the Compliance, Assurance & Learning Sub Committee and escalation through performance reviews and Quality Committee as appropriate.

Mental Health Act Administration Provision within Acute Trusts

At the latter end of 2016, the MHA Manager held discussions with both Mid Cheshire Hospitals NHS Foundation Trust (MCHFT) and East Cheshire NHS Trust (ECT) regarding their registration with CQC in respect of detained patients. As a result of these discussions a Service Level Agreement (SLA) was agreed between CWP and MCHFT for the provision of MHA Administration and training; following their re-registration approval this agreement commenced on 23 December 2016. The MHA Manager is now in the process of planning appropriate training for MCHFT staff, as well as setting up due process.

Moving forward for 2017, continuing discussions with ECT are working towards implementing an SLA for MHA Administration following their registration with CQC. As with MCHFT, this will include appropriate training.

The MHA Team have, for several years, provided a service to Arrowe Park Hospital in respect of MHA Administration. A governance framework is in place but a formal SLA to bring this in line with MCHFT and ECT is to be developed. Approaches were made to the Countess of Chester Hospital NHS Foundation Trust at the beginning of 2016 regarding MHA Administration, however, this has not progressed. The MHA Manager plans to approach both these Trusts again once the agreement with ECT has commenced.

The development of SLAs with neighbouring acute trusts will ensure adherence with the MHA, ensure patients are both informed of and afforded their rights, and overall improve the care and treatment of patients. This also provides a positive step forward in light of the Cheshire & Merseyside's Sustainability and Transformation Plan.

16_17_118 Appendix 4

Annual CWP KP90 figures

Trustwide annual MHA figures were submitted to the Health and Social Care Information Centre on 11 May, 2016, in respect of "Inpatients formally detained in hospitals under the Mental Health Act 1983 and other legislation, and patients subject to Supervised Community Treatment."

The tables below show comparable Trustwide figures between 2014/15 and 2015/16 benchmarked against national figures:

Admission on section						
Section Type	**CWP 2014/15**	**National 2014/15**	**CWP 2015/16**	**National 2015/16**	**CWP % change**	**National % change**
2	503	27754	499	30627	-0.8%	10%
3	81	7690	81	8246	0%	7%
4	15	354	24	405	60%	14%
136	271	19403	217	22965	-20%	18%

CTO						
	CWP 2014/15	**National 2014/15**	**CWP 2015/16**	**National 2015/16**	**CWP % change**	**National % change**
New CTO	123	4564	111	4361	-10%	-4%
Recalls	74	2369	70	2294	-5%	-3%
Revocations	26	1427	44	1557	69%	9%
Discharges	55	2491	48	2575	-13%	3%

Detained patients resident in hospital or subject to a CTO as at 31 March 2016					
CWP 2014/15	**National 2014/15**	**CWP 2015/16**	**National 2015/16**	**CWP % change**	**National % change**
153	25117	230	25577	50%	2%

Section 19 transfers*			
	CWP 2014/15	**CWP 2015/16**	**CWP % change**
Transfers In	83	228	175%
Transfers Out	96	217	126%

*No national data is available on section 19 transfers

Changes in legal status under the MHA*		
CWP 2014/15	**CWP 2015/16**	**CWP % change**
1657	1799	9%

e.g. Informal to 5(4), Section 5(4) – 5(2), Section 2 to Section 3, Section 3 to Informal.

*National data on changes in legal status under the MHA is not available in a comparable way.

NHS Digital Report – Use of the Mental Health Act: Annual Statistics 2015/16
Published 21 November 2016

Key findings:

- The use of the MHA continues to increase nationally, an increase in the number of detentions of 9%.
- Over the last ten years there has been a national increase of 47% in the number of detentions.
- Over the last four years there has been a national increase of 80% in the use of section 3 following section 2.
- The use of section 136 increased nationally by 18%, however it was noted that the reduction in the use of police custody suites contributed to this.
- The 'as at' figures on 31 March 2016 of people subject to the MHA increased by 2% compared to 2015.
- The number of CTOs nationally decreased by 35, the first decrease in four years.

Summary of Trust figures when benchmarked against national statistics:

- The number of admissions to hospital on section within CWP during 2015/16 declined by 5% compared with the previous year; whereas nationally an increase of 10% was noted. However, the decline within CWP may be, in part, associated with a continued fall in the number of Section 136 implemented – a reduction of 20% compared to a national increase of 18%, as well as the effectiveness of the Trust's community offer.
- The number of changes in legal status has risen both nationally and within CWP:
  Section 5(4), 5(2), informal to section 2 rose nationally by 12%, but 6% within CWP
  Section 5(4), 5(2), 2, informal to section 3 rose nationally by 24%, 28% within CWP.
- The number of new CTOs declined nationally by 4%; with a higher decrease within CWP of 10%. CTO recalls fell nationally by 3%, however the reduction within CWP was by 5%, again suggestive of the effectiveness of the Trust's community offer. However, a substantially higher number of CWP recalls have resulted in revocation, an increase of 69% compared to 9% nationally. This demonstrates appropriate use of CTO recall within CWP for patients requiring a further period of intervention from inpatient services. Nationally there has been an increase of 3% in the number of CTOs discharged, however within CWP there has been a decrease of 13%. The use of CTO continues to be debatable; studies have reported that they do not reduce re-admission for patients with psychosis and so its use is variable nationally (i.e. many other trusts also have reported decreases despite the cumulative overall increase).
- The use of section 5(2) within CWP has increased by 15% compared to a national increase of 9%.
- The largest increase in MHA activity has been the number of section 19 transfers, 175% increase for transfer into the Trust, and 126% increase in transfers out of the Trust. This may be attributed to the care and treatment needs of individual patients, and the pressures on bed availability both within CWP and external organisations (please note that this figure does not represent movement within CWP). Nationally these figures are excluded due to the method of collection being unreliable. A substantial increase has also been noted nationally over the past four years – an increase of 141% transfers in, and 68% transfers out.
- Overall, these figures represent an increase in the use of the MHA within CWP of 9.3%, compared to 9% nationally. This increase, together with a heightened awareness of the right of appeal, and the safeguards of mandatory review, has increased the number of applications to the First Tier Tribunal Service and Hospital Managers' Panels. However, the First Tier Tribunal (Mental Health) does not publish a report of activity and so it is not possible to benchmark against national figures.

The MHA Team will continue to monitor ongoing trends regarding the use of the Act.

NB – The KP90 return has now been 'retired', future data collection regarding MHA activity will be sourced from the Mental Health Service Dataset (MHSDS).

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Living Wage
Agenda ref. no:	16/17/119
Report to (meeting):	Board of Directors
Action required:	Comments and/ or recommendations sought
Date of meeting:	25/01/2017
Presented by:	David Harris, Director of People and OD

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	No
Ensure meaningful involvement of service users, carers, staff and the wider community	No
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	No
Improve quality of information to improve service delivery, evaluation and planning	No
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	No
Effective services	No
Caring services	No
Well-led services	Yes
Services that are responsive to people's needs	No
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	No
Capability and culture	Yes
Process and structures	No
Measurement	No
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	
35T	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
35T	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*

The purpose of this report is to present information to enable the Board to consider what action to take following the announcement of the uplift to the Voluntary Living Wage (VLW) as set out by the Living Wage Foundation.

This is not to be confused with the new Government Living Wage (GLW) for those aged 25 years and over which came in to effect on 1st April 2016.

Background – *contextual and background information pertinent to the situation/ purpose of the report*

In July 2014 the Board approved that CWP should commit to being a Living Wage employer and to the implementation of the Living Wage Foundation's 'Living Wage'. At the time, the LW hourly rate was £7.25. This rate is reviewed by the Living Wage Foundation each November. In November 2014 the rate rose to £ 7.85phr and in November 2015 it rose to £8.25phr. The Board has approved each of the above uplifts to be applied to CWP salaries as appropriate, however in December 2015, it was acknowledged that given the Trust's financial position the ongoing commitment to paying the VLW should be brought to Board for review each year.

The new rate wef 1st November 2016 is £8.45phr

Assessment – *analysis and considerations of options and risks*

A summary table showing the detail of the financial impact of adopting the new VLW from 1st November 2016 is detailed below. Some detail to note:

- The annual cost of supplementing CWP pay for affected staff (based on the position at Nov 2016) rises from £60,130 to £96,421 – an increase of £36,291;
- The impact in 2017/18 would lessen in the event of an A4C pay award wef 1st April. If an award of 1% were to be made, the additional annual cost would reduce to £21,400;
- No prediction is made of a further increase to the VLW in Nov 2017 in the figures below as the board will be consulted again should that be the case.

Change Date	Detail of change	Full Year Cost to supplement VLW	Full Year impact over and above current 2016 supplement cost	Additional pressure for 16/17	Additional pressure for 17/18
01/04/2016	Current cost	£60,131	n/a	n/a	
01/11/2016	Uplift of VLW from £8.25ph to £8.45 phr	£96,421	£36,291	£15,121	
01/04/2017	Assuming A4C 1% pay award	£81,531	£21,400	n/a	£21,400

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*

The Board of Directors is asked to discuss and agree one of the following options:

- Continue to adopt the VLW rate and uplift CWP salaries accordingly wef 1/11/16
- Hold the 2015 VLW rate – ie do not apply the 2016 uplift for an agreed period of time
- Move away from paying the VLW altogether

Who/ which group has approved this report for receipt at the above meeting?	David Harris, Director of People & OD
Contributing authors:	Gill Kelly (author)

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1.0	People and OD Sub Committee	16/01/17

Appendices provided for reference and to give supporting/ contextual information:
Provide only necessary detail, do not embed appendices, provide as separate reports

Appendix no.	Appendix title
n/a	n/a

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Director of Infection Prevention & Control Quarter Three Report 2016/17
Agenda ref. no:	16/17/120a
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	25/01/2017
Presented by:	Andrea Hughes, Director of Infection, Prevention and Control

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
36T	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
36T	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*
Please find Q3 2016/17 report for Infection Prevention and Control (IPC). This is a mandatory requirement and requires noting.

Background – *contextual and background information pertinent to the situation/ purpose of the report*
The Director of IPC or Clinical Nurse Specialist for IPC delivers a quarterly report to appraise the Board regarding IPC activity and any associated risks.

Assessment – *analysis and considerations of options and risks*
The report will detail the IPC team activity during Q3 and acknowledges that there have been no reportable infections during Q3. Two wards were closed due to an outbreak of diarrhoea and vomiting. This report will assure the Board of the obligation from the IPC team and CWP staff to raise awareness of sepsis by educating our front facing staff, reduce mortality and morbidity, for our service users and reduce delay to acute care for our patients with sepsis triggers.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*
The Board of Directors is asked to **note** the IPC Q3 report for 2016/2017.

Who/ which group has approved this report for receipt at the above meeting?		IPCSC – 11/01/2017
Contributing authors:		Helen Davies
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	Chief Executive Infection, Prevention and Control subcommittee.	January 2017

Appendices provided for reference and to give supporting/ contextual information: *Provide only necessary detail, do not embed appendices, provide as separate reports*	
Appendix no.	Appendix title
1	IPC Q3 2016/17 report

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

16_17_120a Appendix 1

Infection, Prevention and Control Q3 2016/17 report

1. The purpose of the report

The purpose of this report is to provide Cheshire and Wirral Partnership (CWP) Board with an update in respect of assurance activity and performance for which CWP is responsible for during Quarter 3. The report will also update the Board with the progress of the Sepsis Care Improvement Programme (SCIP) Group, which is a task and finish group consisting of staff from various professional disciplines.

2. IPC activity

During Quarter 3 there have been two ward closures in our inpatient areas due to outbreaks of diarrhoea and vomiting with no causative organism identified. Rosewood was closed in November 2016 for 4 days affecting 4 service users and 5 members of staff. Meadowbank closed in November 2016 for 7 days affecting 6 service users and no staff.

There have been no reportable infections during the period of Q3.

A total of 555 staff have attended IPC training, including induction during the period of Q3 and at the end of December 2016 82% of staff Trust wide were compliant with IPC training.

3. Sepsis Care Improvement Programme (SCIP)

When people suffer from sepsis, their immune system goes into overdrive, setting off a series of reactions, including widespread inflammation, swelling and blood clotting. This can lead to significant decrease in blood pressure, which can reduce the blood supply to vital organs, starving them of oxygen. If not treated quickly, sepsis can lead to multiple organ failure and death. However in many cases sepsis is avoidable and is treatable.

In May 2016 a report went to the Quality Committee via the PSESC Chair outlining the Sepsis Action Plan for CWP (Appendix 1). This report identified actions and assurances in relation to the standards and requirements set out in the NHS England (NHSE) document, “Improving outcomes for patients with sepsis - A cross-system action plan” published in December 2015.

CWP had systems in place to manage and monitor the physical health of our patients, the Early Warning Score (EWS) system had been in place across all inpatients areas since April 2012. Additional support is available via the IPC Team to support complex cases. The Trust has now adapted the NEWS (National Early Warning Score) and PEWS for patients that are pregnant

A successful application was made to Advancing Quality Alliance (AQuA) to build on the progress already made in reducing deaths and patient harm from sepsis and allows the sharing of best practice. The Achieving Effective, Reliable and Sustainable Sepsis Care Programme saw the start of CWP’s sepsis improvement team, now known as the SCIP (Sepsis Care Improvement Programme) Group. Jen Adams, IPC Specialist Nurse is Lead Co-ordinator for the group comprising of an AQuA mentor representation from Clinical Governance, Pharmacy, Out of Hours Service, Clinical Training, Adult & Older People’s Mental Health Services & Clinical leads from the planned pilot sites.

4. Progress of programme to date

The SCIP group aims to raise awareness through education, and by introducing a process that provides staff with actions required where sepsis is suspected. An e-learning programme is currently being written that will be specific to CWP’s needs. The group will introduce triage forms to help support and record observations and identify required actions. These will be based on the UK Sepsis Trust forms already in existence, and will use established language and paperwork in order to enhance consistency. The planned triage forms will work alongside the existing NEWS and PEWS where a situation arises that leads to the question, “Could this be sepsis?” There will be a pilot

programme before a risk assessed, targeted roll out across the trust. The identified pilot sites are Meadowbank Ward at Springview, and the Out of Hours Service.

The formation of the SCIP Group will allow CWP to raise awareness of sepsis by educating our patient facing staff, reduce mortality & morbidity for our service users and reduce delay to acute care for our patients with identified sepsis triggers. Data will be gathered in order to produce evidence of the effect of the programme of education, and in addition with regard to the use of the sepsis process.

5. Recommendations

The Board of Directors is asked to note the DIPC Q3 report for 2016/17.

Appendix 2

Sepsis report and action plan

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Safeguarding Report –Quarter 3 2016/17
Agenda ref. no:	16/17/120bi
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	16/01/2017
Presented by:	Avril Devaney Director of Nursing ,Therapies and Patient Partnership

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	No
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	No
Be recognised as an open, progressive organisation that is about care, well-being and partnership	No
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	No
Well-led services	No
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	No
Capability and culture	Yes
Process and structures	Yes
Measurement	No
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
35T	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	
35T	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*

This report is to give the Board and an overview of Safeguarding activity in Q3 2016/17 and a position statement on the implementation of key objectives set.

The report gives an overview of safeguarding inspections and reviews that CWP have been involved with.

Background – *contextual and background information pertinent to the situation/ purpose of the report*
This is a Q3 2016/17 report to provide assurance to the Board that CWP are meeting their safeguarding responsibilities.

Assessment – *analysis and considerations of options and risks*
This report gives an overview of safeguarding activity for Q3 2016/17

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*
The Board of Directors is asked to note the report and progress of key objectives.

Who/ which group has approved this report for receipt at the above meeting?		Trustwide Safeguarding Sub committee
Contributing authors:		Satwinder Lotay
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
0.1	Trustwide Safeguarding Sub committee	12 January 2017

Appendices provided for reference and to give supporting/ contextual information: *Provide only necessary detail, do not embed appendices, provide as separate reports*	
Appendix no.	Appendix title 35T
Appendix 1	Safeguarding Report Q3 2016/17

CWP Safeguarding Adults and Children (including Children in Care) Quarter 3 2016/17 Report

1.0 Purpose of the Report

The purpose of this report is to provide Cheshire and Wirral Partnership (CWP) Board with an update in respect of assurance activity and performance for which CWP is responsible for during Quarter 3.

The report provides continuing assurance of how the Trust has met its responsibilities and requirements as a regulated provider under Regulation 13 of the Health and Social Care Act 2008, The Care Act 2014, the Children Acts of 2004 and 1989, the statutory guidance Working Together to Safeguard Children, 2015 and Promoting the Health of Looked After Children, 2015.

2.0 Board assurance Frameworks- Risk Register

The risks relating to safeguarding on the CWP Board Assurance Framework are reviewed, mitigated, and monitored by the Trustwide Safeguarding Sub-committee. The two risks have been reviewed; one in relation to compliance with the Safeguarding Children Intercollegiate 2014 remains. The second risk - Implementing the learning from Sexual Abuse Inquiry (previously known as Goddard) and Bradbury Investigation has been archived in December 2016 as a review has been undertaken by CWP.

3.0 Safeguarding Activity

CWP Nurse Specialists for Safeguarding Adults receive enquiries for advice and support from CWP staff in relation to safeguarding issues. The outcome of these discussions may result in the concern that has been raised, being managed locally within the service or in a referral to the appropriate Local Authority safeguarding services. In quarter 3 there have been 249 enquires. The process for capturing number of enquiries made to the safeguarding children team has been strengthened and has shown that the safeguarding children team have received 379 enquiries. Safeguarding supervision uptake remains high with 281 cases being discussed within this reporting period.

CWP have made one referral via the Prevent route, which have been discussed at the respective Channel Panel. CWP continues to attend monthly MARAC meetings, which operate across Cheshire East, Cheshire West and Wirral. CWP have increased the pool of MARAC representatives to support the safeguarding Nurse Specialists in managing the process. The number of meetings and the number of cases discussed are comparable to last year.

The Children in Care team are working collaboratively with the local authority and health providers to ensure the health needs for the unaccompanied asylum seekers who have come to Cheshire West and Chester Local Authority are identified and have care planned appropriately.

4.0 Safeguarding and Prevent Training

Safeguarding and Prevent Training compliance rates are detailed in the respective tables below. The level 3 training compliance has increased by 14% in quarter 3 from 52% to 66%. There is currently an action plan in each locality to improve the Level 3 training compliance to above 80% by the end of March 2017. The Trustwide Safeguarding Subcommittee scrutinise the training compliance against the predicated milestones to ensure that this will be achieved and hold the services to account.

Table 1 Safeguarding Training Compliance Rates for CWP at end of Decmeber 2016

Safeguarding Training	Trustwide Compliance Rate at End of December 2016
Level 1 (children and adults includes domestic abuse)	87%
Level 2 (children and adults includes domestic abuse)	86%
Level 3 (safeguarding	66%

children only)	
Level 4	100%
Level 6 (Board training)	100%

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The Prevent Wrap training for CWP staff is mandatory and the compliance as at end of Decemebr 2016 are detailed in Table 2 .

Table 2: PREVENT WRAP Training Compliance on 3 2016.

PREVENT	Trustwide Compliance Rate as at 30/09/16
Level 1 and 2	70%
WRAP 3 (level 3)	86%

5.0 Serious Case Reviews/ Serious Adults Reviews/ Domestic Homicide Reviews

Since Septemebr 2016 the following review activity has been undertaken:

- One SCR has commenced in Wirral and one in Cheshire West and Chester Local Safeguarding Children Board
- Awaiting the outcome of SCR panel on two cases (one case from Cheshire West and Chester Local Safeguarding Children Board and one case from Wirral Local Saferguarding Children Board)
- One SAR completed (Trafford Local Safeguard Adult Board) Awaiting publication. CWP Action plan being implemented
- One IMR commenced for Practice Learning Review (Cheshire West and Chester Local Safeguarding Adult Board)
- One Domestic Homicide Review still to commence (East Cheshire Community Safety Partnership)

CWP have provided 3 chronologies on cases for serious case review panels. There are two safeguarding children multi-agency reviews that are still pending in which CWP services will be involved. CWP have provided no chronologies for serious adult reviews in this quarter. Three safeguarding adult multiagency case reviews are pending and due to the significant time delay in starting these, CWP have raised this at the Local Safeguarding Adult Board and the Clinical Commissioning Group. CWP have referred one case for serious adult review consideration.

6.0 Inspections

During this quarter CWP have not been involved in any inspections. However the Care Quality Commission safeguarding report (Children looked after and safeguarding review in Cheshire East 2016 (CQC 2016)) has been published in December 2016 and CWP are implementing the action plan which is being overseen by Trustwide Safeguarding Subcommittee. CWP continue to support the Improvement Board in Wirral.

CWP are currently implementing the Section 11 action plan following a review against the standards set by CWAC LSCB and the NHS Self-Assessment Audit for Safeguarding Children. The action plan is overseen by Trustwide Safeguarding Subcommittee.

7.0 Trust Wide Objectives for 2016/17

Progress of the objectives are as follows:

Reviewing and implementing the intercollegiate document for adult safeguarding- This is currently on hold following the withdrawal of the document.

Preparing for Goddard inquiry and reviewing the lessons from Bradbury Investigation and implement learning within CWP. Review has been completed and an action plan has been developed.

Safeguarding Strategy for CWP to be refreshed- this is due to go to Board in January 2017.

Align CWP priorities with the respective safeguarding boards on Wirral, Cheshire West and Chester and Cheshire East. The priorities have been reviewed and CWP have aligned the work plan accordingly.

Promote the use of evidence assessment tools to support safeguarding practice. The training has been implemented and work to ensure this is embedded is progressing.
Continue to work with services in ensuring robust safeguarding processes are in response to the integrated agenda. This work has commenced.

8.0 Conclusion

CWP has continued to work in partnership across each of the local Safeguarding Boards for both adults and children. Safeguarding activity continues to remain at a high level across the organisation. The report demonstrates how CWP is responding to the key objectives set for 2016/17.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Safeguarding Strategy and Commitment
Agenda ref. no:	16/17/120bii
Report to (meeting):	Board meeting
Action required:	Discussion and Approval
Date of meeting:	16/01/2017
Presented by:	Avril Devaney Director of Nursing ,Therapies and Patient Partnership

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	No
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	No
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	No
Be recognised as an open, progressive organisation that is about care, well-being and partnership	No
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	No
Well-led services	No
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	No
Capability and culture	Yes
Process and structures	Yes
Measurement	No
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
35T	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	
35T	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*

This report is to introduce the safeguarding strategy for 2017- 2020 which outlines CWP commitment to safeguarding children and adults.

Background – *contextual and background information pertinent to the situation/ purpose of the report*
CWP are required under the standards set by NHS Safeguarding Assurance Framework that health providers should have a safeguarding strategy.

Assessment – *analysis and considerations of options and risks*
The strategy produced is to ensure the commitment is in line with the Person Centred Framework, in line with zero harm and is aligned with CWP vision and encompasses CWP values. The Strategy will be supported by an action plan which will contain the detail of how the plan is to be delivered, by whom and will set milestones for achievement. The action plan will provide the flexibility to adapt to the changing demands, regulatory and statutory requirements and will be monitored at the Trust wide safeguarding sub-committee which reports to the Quality Committee

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*
The Board of Directors is recommended to **approve** the strategy.

Who/ which group has approved this report for receipt at the above meeting?		Trustwide Safeguarding Sub committee
Contributing authors:		Satwinder Lotay
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
0.1	Trustwide Safeguarding Sub committee	12 January 2017

Appendices provided for reference and to give supporting/ contextual information: *Provide only necessary detail, do not embed appendices, provide as separate reports*	
Appendix no	Appendix title 35T
Appendix 1	Safeguarding Strategy 2017-2020

CWP's Strategy and Commitment to Safeguarding 2017-2020

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

CWP Commitment is "Delivering Person Centred Care to Children and Adults"

CWP Vision "Leading in partnership to improve health and well-being by providing high quality care."

CWP Values Care Compassion Competence Communication Courage Commitment

Zero Tolerance

Our Commitment to Patients, Carers and Staff

- This commitment will help to ensure that personalised safeguarding practice is embedded into everyday practice of all employees (including volunteers) within CWP. It will ensure that effective measures for safeguarding are integrated into the trust core business, planning and service delivery.
- We have made a commitment to promote the key message that

  "safeguarding is everybody's responsibility"

  By:

  - A continued delivery of education and training
  - Working with key stakeholders
  - Embedding safe recruitment practice at CWP.
  - Enhancing patient care (and their families and / Or their carers) in safeguarding activity in order to improve the patient experience
  - Providing safeguarding support to all staff from a skilled safeguarding team
- Ensuring that individuals and their families/carers are identified and provided with early help. A "think family" approach is adopted in all safeguarding practice.
- Ensuring staff report and respond to safeguard those who are experiencing or at risk of abuse ,neglect and / or exploitation and are unable to protect themselves
- Embracing to multiagency working to ensure individuals and their families/carers are effectively safeguarded
- Ensuring continued collaborative working with the LSCBs and LSABs across CWP footprint.

Embracing and Building Confidence and Capability

CWP colleagues will:-

- Provide high quality safeguarding training and development opportunities for all staff across the Trust. Training is delivered to meet the requirements of the respective Intercollegiate requirements and statutory guidance.
- Provide advice, support and information , ensuring that policies and procedures are accessible, reviewed and updated regularly
- Support our staff across the whole organisation (including volunteers) to contribute to the implementation of the commitment and actively support the safeguarding agenda by adhering to all safeguarding children , adult (including domestic abuse) policies by:
- Seek specialist safeguarding support and supervision when required.
- Work with the safeguarding team to ensure that patients who are at risk are safeguarded appropriately to meet the individual (and families /cares) needs.
- Investigate and learn from safeguarding incidents.
- Participate in multiagency case reviews and audits

Measuring Progress

We will:

- Work towards achieving and sustain compliance with all requirements of best practice
- Review and agree key performance indicators across the organisation ensuring they are in line with local and national safeguarding and early help agendas
- Maintain a high level of compliance (above 80%) with all levels of safeguarding training.
- Ensure that the Safeguarding Practice Link model is developed across all areas of CWP to support effective safeguarding practice. SPLs are identified in all Clinical teams across the CWP footprint.
- Blend methodology to ensure changes/ improvement in practice are implemented and sustained.

Underpinning Requirements

Health and Social Care Act 2008, The Care Act 2014, The Children Acts of 2004 and 1989, Modern Slavery Act 2015

Mental Capacity Act 2005 Working Together to Safeguard Children, 2015 Promoting the Health of Looked After Children, 2015

NHS Safeguarding Assurance Framework Building Safer Partnerships

Female Genital Mutilation 2015 Serious Crime Act 2015

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Care Quality Commission Registration & Statement of Purpose – Update
Agenda ref. no:	16/17/121
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and approval
Date of meeting:	25/01/2017
Presented by:	Dr Anushta Sivananthan – Medical Director/ Executive Lead for Quality

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	No
Capability and culture	No
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
N/A	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
N/A	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*

To provide an update to the Statement of Purpose and CQC registration in line with the business cycle for the Board of Directors.

Background – *contextual and background information pertinent to the situation/ purpose of the report*

The Statement of Purpose was last approved at Board in September 2015 at the time of addition Westminster Surgery to the Trust's registration. The Trust is required to update the statement of purpose in line with the registration guidance outlined by the CQC at the point of any changes to service provision.

Assessment – *analysis and considerations of options and risks*

The statement of purpose has been updated in conjunction with business support managers and clinical service managers within each locality. All locations and addresses have been reviewed to ensure that they are up-to-date and, where necessary, amendments have been made to ensure accuracy. The key amendments are the inclusion of Ancora House, which opened in September 2016. In addition, an application has been made to remove Pine Lodge from the list of registered locations; whilst this is reflected in the Statement of Purpose, the formal update of CWP's registration was confirmed by the CQC on 9th January 2017.

Each community location has also been noted as either a hub or a satellite to assist the CQC in understanding the main locations from which care is provided.

The description of services provided by the Trust has also been updated; the most significant amendments have been made in relation to Substance Misuse Services to reflect the current service provision.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*

The Board of Directors is asked to **note** the information held within the Statement of Purpose and **approve** the submission to the CQC registration team.

Who/ which group has approved this report for receipt at the above meeting?	David Wood, Associate Director of Safe Services
Contributing authors:	Elspeth Fergusson, Compliance Manager

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	E Fergusson to D Wood and H Cavanagh	23/12/2016
2	D Wood to L Brereton for Board of Directors	17/01/2017

Appendices provided for reference and to give supporting/ contextual information:

Appendix no.	Appendix title
1	CWP Statement of Purpose – Revised January 2017

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

CHAIR'S REPORT
AUDIT COMMITTEE – 10th January 2017

The following is a summary of issues discussed and any matters for escalation from the January 2017 meeting of the Audit Committee:

Internal Audit progress update
The Audit Committee was updated on the completion of recent work including audits on Core Financial Systems and the Joint Venture Partnership. Both attained significant assurance. A briefing note was also issues for a review of the quality monitoring of care of out of area placements.

Future audits were reviewed and assurance was provided from MIAA that the 16/17 audit plan will be fully delivered by year end.

The Committee also reviewed the follow up to pervious audit recommendations report.

External Audit update
The draft external audit plan for 2016/17 was presented. This provided a comprehensive overview of the audit work planned. The Committee reviewed the financial risks identified in the audit plan. A further report on this and management action will be provided to the February meeting.

A technical update was also provided with recent sector updates.

Anti- Fraud
A progress report was provided highlighting completion of recent work. This included recent pieces of work highlighted for review by the Committee. The Fraud, Bribery and Corruption Policy had been updated and was approved by the Committee subject to cross referencing with the Corporate Governance Manual. A anti- fraud follow up report was provided to assure the Committee that actions are being implemented.

Strategic Risk Register
The Committee reviewed the risk register. The recently archived risks were discussed and noted. The Committee highlighted the CIP risk should be re-escalated reflecting the external audit financial risks.

Governance Matters
The Chair's reports/ minutes of recent Operational Board and Quality Committee meetings were reviewed. There were no items for escalation to the Board.

Following the meeting, Committee members met with Trust officers from Safe Services and Finance to review the external audit contract which is due to end in July 2016, with an option to extend for two years. A report will be provided from the Audit Committee to the January 2017 Council of Governors.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

CHAIR'S REPORT –
QUALITY COMMITTEE
4 JANUARY 2017

The following issues and exceptions were raised at the Quality Committee, which require escalation to the Board of Directors:

- **Strategic risk register**
  The main points to note are (i) there is a risk that is in-scope around the CWP workforce not having sufficient capability (capacity, confidence, competence) and resilience to deliver place-based systems of care – this will take a more strategic view than the current disparate risks related to workforce; and (ii) a number of longstanding risks that the strategic risk register process has not effectively assisted in navigating mitigation of them have been archived in their current guise following an in-depth review by the Associate Director of Safe Services and in conjunction with the respective risk leads. One of these strategic risks, that the Board is specifically discussing at today's meeting, is around the effective investigation of serious incidents. The Board is considering the national CQC report "Learning, accountability and candour", alongside the current continuous improvement plan in place post-Mazar's report, to identify specific residual strategic risks for the Trust.
  The Board of Directors is asked to note the exceptions to the strategic risk register highlighted above and to endorse the strategic risk register being presented today.

- **Improving quality through collaborative working – Princeway Community Care Team**
  A presentation was received on how the Princeway Community Care Team, through improved communication and information sharing between them and primary and secondary care, have achieved person-centred care particularly through improving the continuity of care. A discharge planning model is in place which promotes and enables multi disciplinary working in real time in order to reduce inappropriate lengths of stay and promote living independently. The Quality Committee recognised this work as an exemplar in improving quality through collaborative working and the advantages of extending the scope, in line with STP work, to out of area hospitals and by promoting more integration with mental health.
  The Board of Directors is asked to note this model of working as one example as it goes on to discuss, through its future agendas, place-based systems of care as part of local delivery systems.

- **Suicide prevention strategy**
  The Quality Committee received the CWP Suicide Prevention Strategy 2016 – 2020. It has been developed with and will be implemented collaboratively with people who deliver the Trust's services and those who access the Trust's services. It is based on the key policy documents and current research on suicide and suicide prevention. The strategy's main focus is reducing the risk of suicide in those people known to CWP services. This is in acknowledgement that approaches to prevention must be wide-ranging, as such the strategy also includes a framework for working collaboratively with other key stakeholders involved with the Champs collaborative. As CWP is aligned with the Cheshire and Merseyside "NO MORE: Zero Suicide" strategy 2015/20, and given the Trust's own frameworks such as Zero Harm and Person-centred, it is considered that the strategy will facilitate a robust approach to the prevention of suicide across the Trust's footprint and also regionally. The Quality Committee was asked to comment on the Trust's strategy and identified no changes, however some areas to strengthen it, particular language around person-centredness and co-production, as well as educational elements including Human Factors.
  The Quality Committee has acknowledged that suicide is a major social and public health issue and that the most significant gains will be made through the work of the "Champs Public Health Collaborative". As such it recommends regular discussion of the regional suicide strategy, informed by the Trust's contribution through its own strategy, at the Health and Wellbeing Boards.

Jim O'Connor
Non Executive Director/ Chair, Quality Committee